

USER'S MANUAL

TABLE OF CONTENTS

TABLE OF CONTENTS....1
HOW TO USE THIS MANUAL....8
RECENT ADDITIONS TO QUICK-MD....9
FEATURES, FUNCTIONS AND CONCEPTS....25
A Word or Two on Navigation....25
Online Help....25
Yellow Fields....25
RESPONSIBILITY CODES....26
FOR LOUISIANA KIDMED USERS ONLY....26
Billing Notes....27
Payment Posting....27
Ledger Date....27
Date Fields....27
QUICK-REFERENCE – A TYPICAL DAY IN THE OFFICE....28
Scheduling Quick-Reference – Using Q-Schedule....28
Function Keys used in Q-Schedule....28
Scheduling an Appointment....28
Deleting an Appointment....28
Moving an Appointment....28
Verifying Appointments....28
Printing Super Bills....29
Reports....29
Scheduling Quick-Reference – Using Multi-View Scheduler....29
Function Keys used in the Multi-View Scheduler....29
Scheduling an Appointment....29
Deleting an appointment....29
Moving an appointment....29
Verifying Appointments....30
Waiting List....30
Adding a patient to the waiting list....30
Booking a patient from the waiting list....30
Printing Super Bills....30
Reports....30
Entering New Patients....31
Looking Up Patients....31
Entering Charges....31
Working in the Patient's Ledger....31
Deleting Patients....32
Recapping Transactions Quick-Reference - Daily Recaps....32
Billing Quick-Reference
....32
How Quick-MD Bills....32
Batch Billing Paper Claims....33
Batch Billing Electronic Claims....33
Printing an Individual HCFA 1500 form....33

Payments Quick-Reference – Posting Payments....33
Ledger....33
....33
Posting Modules....33
IMPLEMENTING QUICK-MD FOR THE FIRST TIME....35
Installing Quick-MD....37
Installing Quick-MD on the Server....37
Installing Quick-MD on the Clients....37
Installing Q-Schedule on the Clients....37
Setting up Mobile X-Ray....37
Configuring Quick-MD - THE TABLES MENU....38
ICDM (Diagnosis) CODES....39
Add Diagnosis Record....39
Edit Diagnosis Record....39
Deleting Diagnosis Record....40
Print Report....41
CPT CODES....43
Adding CPT Code Record....43
Fee Schedule....44
Edit CPT Code Record....46
Delete CPT Code Record....47
Print Report....47
REFERRING PHYSICIANS....49
Adding Referring Record....49
Edit Referring Record....50
Delete Referring Record....51
Print Report....51
Downloading Reports to Text Files....52
Print Labels....54
INSURANCE COMPANIES....55
Add Insurance Record....55
Edit Insurance Record....56
Delete Insurance Record....58
Print Report....59
Drug Table....61
Add Drug Record....61
Edit Drug Record....61
Delete Drug Record....61
Print Report....61
Customizing Quick-MD - THE PROPERTIES MENU....63
Office Demographics....63
Office Data....63
Provider Table....65
Id from Refering Physician Table –....65
Insurance ID Numbers....66
Location Table....67
Payment Table....67
Adjustment Table....68
Financial Class Table....69
Patient Source Table....71
Sort Code Table....72
Patients....72
Patient Defaults....72
Patient Custom Information - Male....73
Patient Custom Information - Female....73
Recall Table....75
Browser Defaults....76
Patient Dunning Notices....77
Marital Status Table....77
Employment Status Table....78

Relationship Table....78
Standard Appointment....79
Appointment Defaults....79
Charge Entry....80
Cpt Entry Options....80
Place of Service Table....82
Type of Service Table....83
Modifiers Table....84
Set 1500 Extra Data Fields....84
Printed Forms....85
Printer Settings....85
HCFA 1500 Settings....85
Using the Test Grid....86
Patient Statement Settings....87
Super Bill Settings....88
Laser/Inkjet Address Label Settings....89
Other Form Setup....90
Texas Worker's Compensation Work Status Report....90
Texas Worker's Compensation Medical Evaluation Report....91
Options....91
Miscellaneous Defaults....91
Auto Check E-Mail: Click this box on if you want the system to automatically check your email for you....94
Medical Records Settings: 96
Other Defaults: 98
Third party information:....99
Table Data Paths....99
Electronic Filing....100
Electronic Medicare, Medicaid, Blue Cross and Clearing House Settings....100
Electronic Remittance Settings....103
SCHEDULING APPOINTMENTS IN QUICK-MD....105
Using Q-Schedule....105
Setting Up....105
Using Templates....105
Using The Scheduler 106
Create an Appointment....107
Moving Appointments....108
Blocking an Entire Day....108
Pg Up/Pg Dn....108
Reports....108
Print Appointment Listing....109
Print Appointment Listing for a date range....109
Print Super Bills....110
Search For Existing Appointment....110
Query Appointments....111
Next Av....112
Referring Physician Report....112
Appointment Audit Report....112
Appointment Settings....114
Set Appointment Reasons 115
Set Provider Names....115
Set Super Bill Data 115
Using the Standard Appointment Scheduler....117
Moving Appointments....119
Using Templets....119
Using the Appointment Functions....120
Multi-View Scheduler....124
Setting Up....124
Show Status – If this option is set the status for the appointment will print on the List Appointments for a Day report. 125
Set Provider Names....126

Setting up groups....127
Set Appointment Reasons....128
Setting Super Bill Coordinates....129
Set status codes....130
Set Color Description....131
File maintenance utilites....131
Using the Scheduler....132
Create an Appointment....133
Waiting List....135
Adding a Patient to the Waiting List....136
Booking a Patient from the Waiting List....136
Appointment Reports....136
List Appointments For a Day....137
Print Listing for a period....137
List Appointments Combined....137
Query Appointment Status Codes....138
Appointment Audit Report....138
Batch Print Super Bills....139
Third Party Export....139
List Templets....139
Check Eligibility....140
Next Available....140
Patient Search....142
E-Mail....142
Jump To....143
Templet....143
Hi Resolution Appointment Scheduler....144
Day View....145
Next Available by color....146
THE FILE MENU....147
Add a New Patient File....147
Duplicate Patient Window....150
Entering Patients Insurance Information....151
Historical Primary Insurance Companies:....153
Secondary Insurance....154
Historical Secondary Insurance Companies:....155
Third Insurance....155
Other Features of the Patient Demographics Screen....156
[Statement] - Patient Statement Information....156
[diagnosis] - Patient Diagnoses Table....157
[!off msg] - Inner Office Messages....159
[state msg] - Statement Message Box....159
[emg] - Emergency Contact....159
[soft 2] - Other Sort Codes....160
Print....160
Data Output Processor....160
[ledger] - The Ledger....162
Patient Ledger....162
Enter Charges New Claim....163
Charge Entry Screen....163
Other Charge Information Screen....165
The Payments Screen - using Un-Applied Credits....168
Supplier Other Information Form....170
Enter Charges Patient Claim....171
Add Charges To Last Claim....171
Current Ledger....172
History Ledger....178
Dependant Balances....180
Dependants....180
Exit....180

[balances] - Patient Ledger Balances....182
[Info] - custom information screen....182
[co%] - Co-Percent & Deductible....182
To implement this feature based on a percentage:....183
To Implement this feature based on a fixed dollar amount:....183
Session Information:....184
[CONTRACT] - Contract Payment Information....184
[recalls] - Patient Recalls....185
Using Un-Applied Credits....187
Configuring Quick-MD to handle Un-Applied Credits....187
Accepting Un-Applied Credits....188
Applying Un-Applied Credits....189
Applying Un-Applied Credits during Charge Entry....189
Applying Un-Applied Credits using the Payment Posting Modules....189
[managed care] - MANAGED CARE MODULE....190
[cpt] – Cpt Code Tracking....192
ELECTRONIC MEDICAL RECORDS....193
Setting up the Electronic Medical Records Interface....194
Attaching documents to patient's file....196
OPERATIVE TRANSCRIPTIONS....196
Reviewing Operative Transcription's....198
OTHER DOCUMENTS....199
Using Templates....199
Insertion Commands....199
Using the Naming Convention....201
Creating and Attaching Other Documents to a Patient's File....202
Reviewing/Editing Attached Documents....203
Patient Phone Messages....205
Adding a New Message....206
Tracking and Printing of Prescriptions....208
[FORMS] – Texas Workers Compensations Forms....210
Lookup Patient File....211
Look Up Patient File Screen....211
Patient Files Browser....212
Fast Charge Entry....213
Open Patient Ledger....214
Delete Patient File....214
BILLING IN QUICK-MD....216
How Quick-MD Bills....216
THE BILLING MENU - (Paper Filing)....216
Patient Statements....216
Primary Insurance....219
Secondary Insurance....221
Third Insurance....221
REBILL CLAIMS....222
Report Last Batch Printed....222
Delete Billing Notes For Last Batch Printed....222
THE E- BILL MENU (Electronic Filing)....223
E-Billing Medicare, Medicaid, Louisiana Blue Cross Blue Shield and Ochsner....223
Electronic Clearing House Billing....227
E-Bill Reports....227
ELECTRONIC REMITTANCE (ANSI 835)....228
835 Report....229
Loading the 835 file....230
ENTERING PAYMENTS IN QUICK-MD....231
THE PAYMENTS MENU....231
Patient/Insurance Payments Posting....231
Quick Insurance Payment Posting Module – By Claim....233
To Save an Unfinished EOB Posting....235
Resuming an Unfinished EOB Posting....235

Insurance Payments By Invoice....236
Patient/Insurance Payments (By Invoice/Uc) – (Unapplied Credits)....238
RECAPING TRANSACTIONS FOR A DAY IN QUICK-MD....242
THE RECAPS MENU....242
Daily Recap....242
Sample Daily Recap Report....242
Daily Payments....243
Sample Daily Payments Report....243
Daily Charges....244
Sample Daily Charges Report....244
Daily Adjustments....245
Sample Daily Adjustments Report....245
....245
Recap Summary For a Time Period....246
Sample Recap Summary for Time Period Report....246
ANALYZING YOUR INFORMATION IN QUICK-MD....247
THE REPORTS MENU....247
Query Patient File....247
Query Payments....248
Sample Query Payments Report:....249
Query Adjustments....250
Sample Query Adjustments Report:....250
Query Charges....251
Sample Query Charges Report:....252
Mail Merge....253
Print Labels....255
Ageing Report (Brief)....256
Sample Ageing Report (Brief):....257
Aging Report (Detailed)....258
Sample Ageing Report (Detailed):....259
Ageing Report (for one insurance company)....260
Sample Ageing Report (For one Insurance Company):....260
Aging Report (All Insurance Companies)....261
Sample Ageing Report (For All Insurance Companies):....261
Ageing Report (By Claim)....263
Sample Ageing Report (By Claim):....263
Financial Class Ageing Summary Report....264
Sample Financial Class Ageing Report:....265
Collections Work Report....266
Sample Collections Work Report:....267
Cpt Codes Analysis Report....268
Sample CPT Codes Analysis Report:....268
Payment Analysis By Cpt Code Report....269
Sample Diagnosis Codes Analysis Report:....270
Charge & Payment For Companies Set In Patient Responsible....271
Average Reimbursement Report....272
Sample Reimbursement Report....272
Insurance Claims Not Billed....273
Sample Insurance Claims Not Billed Report:....273
Claims With Credit Balances....274
Sample Claims with Credit Balances Report:....274
Claims With Balance Owed....275
Sample Claims with Balance Owed Report:....275
Managed Care Expirations....276
Sample Managed Care Expirations Report:....276
Financial Summary For Providers....277
Sample Financial Summary For Providers Report:....277
General Ledger Summary....278
Sample General Ledger Summary Report:....279

Patient Recall Report....280
List Blocked Bills....281
Sample List Blocked Bills Report:....281
List Late Promise to Pay Payments....282
List Promise to Pay Contracts....283
ADVANCED FEATURES OF QUICK-MD....284
THE SYSTEM UTILITIES MENU....284
Data Files Rebuild....284
Data Files Re-index....285
Reset Lock Fields in Appointments....285
Purge Appointment File....286
Move Ledgers to History....286
Set Operator Rights....286
Edit Zip Code Record....289
Canned Notes....289
Reassign Sort Code....291
Delete Billing Note....291
Generate Contract Ledger Entries....292
Post Re-occuring Charges and Payments....292
Set Next Patient Number....293
Run Deleted Records Ledger Report....293
Check for Orphaned Ledgers....294
INTRA-OFFICE EMAIL....295
SENDING AN EMAIL....296
WAITING ROOM WIZARD....297
Starting The Wizard....297
Patient Information....297
Primary Insurance Information....298
Alternate Billing Information....299
Emergency Contact Information....300
Accessing The Waiting Room Information....300
SETTING UP AND USING THE HL7 INTERFACE....301
Setting up the HL7 interface to send message....301
Running IMED scan as a service....301
IMED Scan 302
Setting up the HL7 interface to read electronic super bills....303
Loading electronic superbills....303
ONLINE TUTORIALS....304
HOW TO....306
FREQUENTLY ASKED QUESTIONS....306
What does a claim consist of?....306
What are Responsibilities Codes?....306
What types of Billing Methods does Quick-MD have?....307
What date is used to determine what information is on the daily recap?....307
How do I perform recaps for only the work I did?....307
Can I Change the Font Size on my Reports?....307
Why do my HCFA forms, Patient Statements or SuperBills not line up from top to bottom?....308
How do I clear a file lock?....308
Exiting Quick-MD....308

HOW TO USE THIS MANUAL

This manual details everything you need to know to effectively run your practice with Quick-MD.

When using this manual you should know that there are four ways to find the information you are interested in. The first is the Table of Contents. The second is the Recent Additions. The third is the FAQ. And the fourth is to utilize the find feature "**<CTRL>+F"** inside Adobe Acrobat to search for specific text.

To navigate this Manual, click on the subject you are interested in viewing in the TABLE OF CONTENTS, which is located behind the Bookmark tab to your left. This will jump you to that section of the manual. When you are at the section you wish to read, you can click the Bookmark tab again to close it and make your document full screen. Additionally, you should know that when ever you see a link that reads *(for more information see page #),* clicking on the page number will jump you to that section of the manual.

After the TABLE OF CONTENTS, you will find a RECENT ADDITIONS TO QUICK-MD section. You should use this section to get an overview of the many different features in Quick-MD. Additionally, each time the software is updated, you will want to use this section to learn about your new features and how to best utilize them.

After this, the manual walks you through installing and configuring the software. If you are setting the program up for the first time, you will want to carefully read this section. Your VAR will walk you through most of this setup, but you should take the time to become familiar with what information you need to gather and to begin thinking about how you want to customize the software to meet the needs of your particular practice.

After the installation and setup section, the manual will walk you through the various aspects of using your new system. It is broken down in a logical order that begins with scheduling, moves through working with your patients, then on to Billing and finally explains how to use the other features of the program that are available to you.

The manual ends with a FREQUENTLY ASKED QUESTIONS section. Use this section to learn how to perform specific tasks that you might be having trouble understanding how to perform.

Sincerely,
The Quick-MD team.

RECENT ADDITIONS TO QUICK-MD

This section of the Manual describes the latest features of Quick-MD as new versions are released. Reading through the list of features is a great way to get an overview of the many intricacies of the program. As new versions of the program are released, you will want to check this section of the Manual to see what new features are added and how to use them.

Version 5.0

- You can now print the Texas Workers Compensation forms DWC-69 and DWC-73. (See Page 147)
- A check box was added to the Insurance/Employer record that you check if the record Represents an employer. On the browse screen the Ins. Companies will be blue and The Employers will be green. (See page 55)
- The patient's DOB was added to the phone messages print out.
- A Complete day view was added to the Multi-View Scheduler. Click on the "D" button to switch to a full day view. Your monitor must be set in at least 1024 X 768 to use this feature. You can do all tasks on the day screen that can be done on the front screen except change the calander day, you must go back to the front screen to change the date.
- The Hi-Resolution Multi-View Scheduler now ready for use. It will allow you to see 8 more time slots per page on the main screen and also has the complete day for a provider booking screen.
- The Query Patient File report will now give you a list of deceased patients.
- A "Date Last Verified" field was added to the patient's insurance screen.
- The patient's diagnosis table now prints when the print button on the patient's demographic screen is clicked.
- You can now set a "Claim Adjustment Reason Code" on the edit charge screen when Medicare is secondary. When the system sees that a Medicare is set as secondary and you edit (F4) a charge the cursor will be in the claim adjustment reason code field on opening of the charge screen.
- In every place in the system that you enter addresses, you can now type the zipcode in the city name and the city, state, and zip will be auto entered. If the zip code is not recognized you will be asked for the info and Quick-MD will recognize it from then On. There will be a red Z by the city name to remind you of this feature.
- You can define your Blue Cross writeoff adjustment code in Properties/Misc. Defaults. If it is defined and you have auto writeoffs turned on it will use the defined code for The Blue Cross write offs on the auto entered adjustments.
- A "Print Canned Notes Listing" button was added to the Canned Notes Menu
- You can now set a Supervising Phy. on the Supplier Information Screen for the claim.
- You can set an associated drug on the CPT Code record. If a drug is set on the CPT record it will automatically set the NDC information on the patient charge entry screen when the operator enters the CPT code. If the NDC information is set the NDC Info Button will say "NDC Info Set" if it is not set, the button will Read "NDC Info".
- A checkbox "Include Primary Insurance" was added to the charges daily recap. If checked it will include the name of the primary Ins. Company under each charge if it is set in the patient's file.
- In the Multi-View and the Hi-Resolution scheduler a "Search By Color" button was Added. It will search for the next available appointment based on the color that is set on the time slot.
- The patient's cell phone number ill not print on the demographics print out.

Version 4.9

- On the patient's insurance screens, if the relationship is set at self and an insurance company ID# is set, the system will display a warning if the first and last name of the subscriber does not match the first and last name of the patient.

- A new report was added to "Query Patient Ledger" in the F9 Ledger Prints Menu. This report will list all claims itemized that have a non-zero balance. The dates on the ledger Query screen are ignored if set for this report.

- All "Daily Recap Reports" now have the check box "Recap All Providers Separately" and work the same as the "Daily Recap Report" described below.

- A visit date from and visit to date was added to the Mail Merge. If these two dates are filled in, the patient must have visited in that date range to be included in the merge. The date of visit is determined by the from date if set or the ledger date if the from date is not set on the charge.

- The age data field in the patient demographics screen has been changed to show the age in months if the patient is less than 2 years old.

- The "Daily Recap Report" now has a check box "Recap All Providers Separately". If this box is checked it will print a recap for each provider that has any ledger entries for the day being run. They will appear in the data output processor one after another.

- A Sort Code selection drop down was added to the "List Blocked Bills".

- You can know run the Daily Recap Report and have it group the reports by the provide. If you go to "Daily Recap Reports" and check the box labeled "Recap All Providers Separately" you will get a separate report for each provider.

- NDC information was added to the charge records. To use this feature your should first enter the drugs your office administers into the drug table in TABLES. You will need to know the NDC number for each drug and the type of units it is issued in. International Units, Milliliter, Gram or Unit. So, before entering drugs you will need to edit your settings. We recommend setting IU for International Units, Mill for Milliliter, Gram for Gram, and U for unit. After the drug table is set up you can then attach a drug when you are entering charges. On the oher charge info screen you will see a button that says NDC info. Click on that button and a screen will appear that will sllow you to browse the drug file and attach a drug to that charge.

Version 4.8

- The provider table in properties was expanded from 26 providers to 50

- A data field for the NDC number was added to the drug table records.

- The Query charges report can now be run by operator.

- You can now run the daily recap reports by operator group codes.

- We added a report to the multi-view appointment system that will let you print a listing of your appointment templates by provider and day of the week.

- The + and – keys will increase or decrease a date field by one day in the other charge information and Edit charge screens.

- You can define your workman's comp financial class to the system now. If you define it to the system (1) When the supplier form pops up it will default 10a to Yes. (2) when you enter the ledger date the from and to dates will default to the ledger date. To define your Workman's comp to the system go to Properties/Misc. Defaults/Other Defaults and type in the number that represents your W.C. Class in the financial class table.

- In Properties/1500 settings & properties/Patient Statement settings a new check box was added. The box is labeled "Use Address In Provider Table Instead of Office Address". If you check this box for the 1500 form it will put the address listed in the provider's table in block 33 instead of the office address. If you check it for the patient statements it will still use the office name on the statements but will use the address listed in the provider's table.

- The ledger report from the ledger print menu always prints in landscape now.

- The query payments and query adjustments reporting can now be narrowed to an operator.

- The electronic clearing house, Medicare and Medicaid direct modules will now sen the NPI number if the check box "Send NPI number" in the electronic filing modules is checked.

- The new CMS 1500 form was added. There is a check box in properties that will allow you to switch back and forth between the new and old 1500 form. The new form must be alighed before trying to use it.

- The date of the last patient's payment was added to the standard and definable patient statement.

- A second default sig line, and a default unit of measurement where added to the drug record.

- A font size can now be selected in the Data Output Processor. See the button at the top that reads Font.

- Expanded location table form 10 to 30. Expanded payment table from 25 to 50. Expanded adjustment table from 25 to 50. Expanded financial class table from 25 to 50. Expanded sort code table from 85 to 99.

- Now able to define two clia id numbers to the system. The one defined under properties/Electronic Medicare Settings is the default clia number used by the system. The one defined under properties/Electronic BCBS settings is the additional clia number. The additional clia number is activated by placing a note, on a lab charge, that contains the text "CLIA2".

- Ability to create templates in Microsoft Word. *(For more information see page 193)*

- Checking "Put Primary Diagnosis on Ledger Browse" under Properties/File Browser Setting, well set the first diagnosis in diagnosis column of the ledger browser screen instead of the pointers to the diagnosis table.

- Added a place for the cell phone number on the patient's demographics screen.

- Added horizontal scroll bar and font size option to the data output processor.

- Changes were made to the prescriptions module. A second Sig line was added. A unit of measurement field was added next to the dispense number. You can set what you need, Pills, Pack, Tube, etc. This is a user defined table of 6 positions that can be set in Properties/Misc. Defaults/Medical Record Settings. Also, the patient's DOB will print on the prescriptions just to the right of the account number and a check box to mark the prescription inactive was added.

- Added new insertion commands. *(For more information see page 199)*

- Added the ability to print address labels by diagnosis code.

- Now you can include the line item diagnosis and provider on the "Itemized by Date Range" Report.

- PDF export for all reports. *(For more information see page 160)*

- A EMR button was added to the patient demographics and current ledger screens. Clicking on this button will start then Medical Records interface and of course you can still start this interface by pressing shift/F1.

- On the drug browse screen you now have the ability to press the F1 key and see all information on that record.

- There are now two print all buttons in the data output processor. One will print all and close the DOP the other will print all and leave the DOP open.

- A new check box was put in Properties/Misc. Defaults. “Strictly enforce ledger date range”. If this box is checked QM will not let the operator exit the ledger date fields of new payments, charges, and adjustments until the ledger date is set within the range specified in Properties/Misc. Defaults. When editing any ledger entries, if the ledger date is not within the set range the ledger date data field will be grayed out and not operable.

- Two new definable super bill data fields were added to the super bill in the Multi-View scheduler. The 2 note fields can be placed on the super bill. To set the coordinates, go to Properties/Super bill setup in the Multi-View scheduler.

- The ability to run the Query Charges Report for a range of NUMERICAL CPT codes was added. The fields for the code ranges on the report are for the CPT code and not the CPT office code. The field for a single CPT code was for the CPT office code but has been changed to use the actual CPT code.

- The Insurance Claims Billed Report was modified. It now has a check box “Use Actual Balance”. If this is checked the report will use the actual balance of the claim as is in the ledger(all charges, payments, adjustments are considered). If it is not checked the report will works as it did in the past which is the dollar amount that was put in block 30 of the 1500 form. Also, totals for Primary, Secondary, and Third billings was added at the bottom of the report.

Version 4.7

- Louisiana Kidmed electronic filing module was added. The Kidmed company must be setup as the third Ins. In the patient’s file. The charges must carry the “A” responsibility code. The Kidmed company must be defined in properties/Ins. ID numbers. The electronic kidmed settings must be set in properties. The file name will be H450????.KID

- The prescription records were changed so that up to 4 prescriptions per record can be added. *(For more information see page 208)*
  Also, a drug table was added to the tables menu. You can now pull the drugs into the prescription records from the table. *(For more information see page 61)*

- On the prescription browse screen you can now highlight a prescription and press The F3 key and a refill will be generated. *(For more information see page 208)*

- On the diagnosis browse screen, you have a complete browse data field. If you enter characters in this field the browse will pull up all records that have that set of characters in the description line no matter where it is on the line. This browse May take longer to come up depending on how many diagnosis records you have on file. (*For more information see page 157)*

- Units of service were added to the daily charges recap report. *(For more information see page 244)*

- Modifiers were added to the daily charge recap report *(For more information see page 244*

- The link codes in the CPT records was expanded from 4 to 8. *(For more information see page 43)*

- A full text search was added to the CPT records browse screen. This allows you to type in any text into the CPT code browse screen and Quick-MD will search for all records that contain this text.

- Price updating was added to the edit charge screen when you pull in a CPT

code from this screen. To work you must turn it on in properties/Misc. defaults.
(For more information see page 91)

- Default sig, refills, and dispense was added to the drug record.
(For more information see page 61)

- During charge entry you can now verify the new patient codes with ranges between 99201 thru 99205 and 99242 thru 99245. This can be turned on in properties/other defaults. *(For more information see page 98)*
The check box will read Verify use of new patient cpt codes. If this is on and one of the above codes is used and there are already entries in this patient's ledger you will get a warning.
11/11/04

- During charge entry you can now have Quick-MD check to see if the cpt code being Entered is listed in the cpt codes tracking table. If the code is not in the table you will Get a warning. For this to work you must have the check box in misc. defaults/ other Defaults that reads "Warn if cpt code is not listed in tracking table checked. *(For more information see page 98*
This will work on All cpt codes that have the track cpt code check box checked in the master cpt code Record. *(For more information see page 43)*
11/11/04

- Seven new data import codes were added to the medical records module. (For more information on using templates in the medical records module see page 199)
[CAID#] This will insert the patient Medicaid # into the document.
[PATPHN] This will insert the patient's home phone #
[FNAM] If this code is found in the document the Ref Phy/ Facility browse screen will appear and allow you to select an entity and then place the entity name into the document. If the [FNAM] is found and the operator selects an entity, then the following 4 codes Will be looked for in the document.
[FADD] This will insert the entities address.
[FCSZ] This will insert the entities city, state, zipcode.
[FPHN] This will insert the entities phone#
[FFAX] This will insert the entities fax#
11/16/04

- The ability to print address labels for referring physicians was added to the Referring physician's Table menu. 11/19/2004

- A new referring physician report was added to the Quick-MD reports menu. 12/03/2004

- 16 new buttons were added to the managed care window. One at the bottom labeled Med Records will start the medical records interface. The other 15 are at the end Of each line and will start the medical records interface with the information carried From that line to the create other document. Five new commands were added to the templates as listed below:
[MEDSERV] This will pop up a box for the user to enter up to 70 characters to be inserted into the document.
[FROMDATE] & [TODATE] This will insert the from and to date from the line on the managed care form.
[REFNUM] This will insert the precert number from the line.
[DIAGS] This will pop up a box where the user can enter two diagnoses in and they, along with their description, will be inserted into the document. 12/21/2004

- A new check box was added for each line in the managed care form. This row of check boxes is labeled "IB". This stands for Inbound. This is for clients that are using the managed care module for tracking inbound and outbound referrals. So the referrals that are inbound can be checked and the outbound will be left unchecked. 12/21/2004

- A diagnosis reference table was added to the charge entry screen.01/05/2005

- Accident Time was added to the supplier info screen. This must be set for Medicare Claims if auto or other accident is set at “Y”. 01/05/2005

- The payment posting modules will now get the check number from the download of the Ansi 835 module. Both the Line item and claim posting modules will do this. This was changed since Medicare now puts multiple checks in the ANSI 835 file. When the payment posting modules see the check number downloaded form the 835 EOB module the check number field will not be visible, but the check numbers will be placed on the posted payments in the patient’s ledgers. 01/25/2005

- Working diagnoses was added to the charge entry screen. 01/16/2005

- The Multi-View scheduler was rolled out. 02/10/2005

- A button was added to the provider table screen. “Other #s”. On this new screen you can add 2 ins. Companies for block 31 and two for block 25 on the paper hcfa 1500 form. If a company is set in any of these fields the license number set will be put in the appropriate place. 02/15/2005

- The provider listed on the claim was added to the patient quick posting module.02/16/2005

- The ability to block billing for an entire claim was added. You can block the primary, secondary, or tertiary insurance billing. Adding a note anywhere within the claim does this. To block primary the description line of the note would be BLOCKI, secondary would be BLOCKS and third would be BLOCKA. Once you delete this note the billing will be picked up. You can add the note from the Charge entry screen by checking the box “Block billing to primary ins” checkbox. The List Insurance Claims Not Billed report will list the blocked claims by putting [Blocked] in front of the Insurance Company name. 02/16/2005

- An adjustment total per provider was added to the line item quick payment posting module. 02/16/2005

- A promise to pay module was added to the contract button in the patient’s demographics screen. It will all you set up, up to 24 expected payments. If it is setup, when the operator enters a payment with the “P” responsibility code in the patient’s ledger or from the patient quick payment module. The system will ask the operator if it is a promise to pay payment. If the answer is yes it will post the payment in the ledger and also into the promise to pay module. There are two reports for the P.T.P module. One will list past due payments and one will list all P.T.P. contracts and there statuses. With the P.T.P. module the entire contract receivable is still in the patient’s ledger not in the P.T.P module. The P.T.P. module just tracks expected payments and lets you know if the payments are not received. 02/23/2005

- A new report option was added to the patient’s ledger print menu. “Query Patients Ledger”. This report has five options to query with. (1) List only payments (2) List Payments and charges (3) List payments, charges, and adjustments (4) List only Charges (5) List only notes. 02/25/2005

- Electronic filing buttons were added to all the ansi electronic filing modules. 03/04/2005

- A new check box was added to browser defaults in properties. Put service date in left Column of ledger browse screen. If checked and the line is a charge with the from Date set it will be put in the left column instead of the ledger date. 03/08/2005

- The print itemized by date range in the ledger print menu was changed to reflect only totals in the date range and not totals of the entire ledger. More detailed totals for the date range where added. 03/08/2005

- In all 3 insurance quick payment posting modules, you may now work in the patients Ledger by pressing shift/F1 while the cursor is in the claim number field. All functionality works as though you are accessing the patient’s ledger from the Patient’s file. 03/08/2005 *(for more information see page 231)*

- A Jump To button was added to both views schedulers. 03/09/2005 *(for more information see page* 143*)*

- The F11 key in the both views schedulers (apply templet) will now pop up a Window for you to pick a day templet to apply. For example, with this feature you can apply a templet from one day of the week to another day of the week. 03/09/2005 *(for more information see page 119)*

- A standard patient statement was added. It will print a patient statement on plain White paper. To use it check the box on the patient statements batch billing screen That reads “Standard Statement”. Note this will have no effect if the file elec. Statements box is also checked. Also, default settings for patient elect. Filing and standard statements can be set in properties/misc defaults/other defaults so the user will not have to remember to check either of the boxes. If the standard statement default is checked here, when you print a patient statement form within the patient’s ledger, the standard statement will be used. The standard statement looks at only two properties in Quick-MD (1) the number of lines on the page in patient statement settings. (2) the font size for statements in printer settings. 03/28/2005 *(for more information see page 216)*

- You can now print a single address label from the patient’s, referring physician’s and insurance’s browse screens. This print job is designed to use either Sieko or Dymo label printers. *(for more information see page 212)*

- Three new insertion commands where added to the medical records module.
  [$PAT] will insert a dollar sign and the patient’s current balance.
  [$ALL] will insert a dollar sign and the entire balance of the ledger.
  [$INS] will insert a dollar sign and the Ins. Balance. 05/11/05 *(for more information see page 199)*

- A new check box was added to the master insurance record screen. “This Is A Medigap Company”. Check this box if this is a medigap company that medicare will cross the claims over to. 05/17/05 *(for more information see page 55)*

- Two new check boxes were added to Properties/Electronic Remittance Settings. Both of these check boxes apply to the claim & line item quick payment posting module.
  1. Auto reassign secondaries – If this is checked when the electronic remittance is downloaded to one of the payment posting modules, if there is a secondary insurance setup for the patient then the reassignment will be set as S.
  2. Auto second billing notes on medigap companies – If this is checked when the post button is clicked on one of the payment posting modules a secondary billing note will be put on the claim if (a) The patient’s second insurance Company has the box “This is a medigap company checked” in the master insurance record. (b) The patient’s primary insurance company is Medicare. (c) The reassign code for the claim or line item is set at S. 05/17/05 (*for more information see page 103*

- An Average reimbursement report was added to the Reports menu. 07/12/2005 *(for more information see page 272)*

- Promise to pay contract balance was added to the super bill in the multi-view scheduler

- Effective date of policy was added to the patient’s subscriber secondary and third insurance screens. These dates, if set, will appear on all Quick payment posting modules. When re-assigning claims to S or A from the payment posting modules it is the operator’s responsibility to check these dates before re-assigning. When working inside the patient’s ledgers, where the operator cannot see the effective date, the system will check them for you when you re-assign a claim. If a date of service on the claim is before the effective date a warning message will appear. 07/26/05

- The read ebill report will now automatically recognize what kind of file you are attempting to open and use the proper reader for the file. So, the read 997 and TA1 options are now gone from the ebill menu. 07/29/05.

- In properties/misc def/other defs, a data field for mammography certification number was added. If this number is placed in the system and a 760?? Mammography code is used then the number will be sent in the electronic files or will be printed in block 32 of a paper claim. 10/20/05

- A new UPIN number data field was added in the provider records in properties. Be sure you set the UPIN number on all providers before doing any billing. 11/08/05

Version 4.6

- A new check box was added to the Ref.Phy/Facility record. It has two options Person or Facility. They will all be Person by default. You must change the Ones in your table that are non-persons to the facility before any electronic Filing can be done. (For more information see page 49)

- A new report was added to the reports menu. “Insurance Ageing Report By Claim” (For More information see page

- You can now default the facility where services were rendered field on the Supplier form. This will work for all new primary Medicare & Champus claims That are put into the ledgers. To do this, (1) Set up your office in the Ref.Phy/Facility Table (2) Set the field in Misc.Defaults/Other defaults/ ID number of your office in the facility table.

- A new menu option “Read E-bill Report” was added to the ANSI E-Billing menu. When you click on this it will bring up the open file dialog. The dialog will open in The folder that is set in Properties/Elect. Remit Settings/Path. (You should set this path the same as your communications software download path.) If a file is selected, the Contents of that file will be placed in the DOP for viewing or printing.
  NOTE: *This Works only on asci text files such as the edit report and reject report returned by Medicare.*

- E-Mail address and work phone number was added to the statement screen of the patient file. The e-mail address is also exported in the Appointment system export Report. *(For more information see page 156)*

- A Pin# can be placed in block 24K for any company. Check the 24K block in the Ins. Record. *(For more information see page 55)*
Make sure the PIN# is set in the provider’s tables in the extra numbers Column or the class column. *(For more information see page 65)*

- A license number for facilities can be printed in block 32 by making sure the Record is marked as a facility and the number is placed in the licenses # data Field. *(For more information see page 49)*

- You can now file BCBC BMS claims in a separate batch with the BCBS electronic Filing module (Louisiana Only). To do this you must set the ID# of the BMS company in the BC Electronic settings in properties. After the number is set a “file only BMS claims” Check box will appear on the electronic filing screen. If you check the box then Only BMS claims will be picked up. Also, the name of the company in the insurance Master file MUST BE BMSSIG.

Version 4.5

- CPT codes tracking was added. There is a check box in the master CPT record to enable tracking for each CPT code desired. If this box is checked in the master record, when this code is entered in the patient’s ledger, it will also make a record of it in the patient’s CPT tracking record. The description will be the description set in the master CPT record “Tracking Description”. If this is not set then the CPT description will be used.
  (For more information see page 43)
- A new button has been added to the Patient Demographic Screen that allows you to view and print your tracked CPT codes.
  (For more information see page 192)
- Diagnosis description was expanded to 80 chars in the master table, but in the patients diagnosis tables it will carry in only 40 chars. Also, an inactive check box was added to the master diagnosis file. When checked it will warn the operator.
  (For more information see page 39)

- A message code was added to the master CPT code record and will display on the charge entry screen if it is set. The message code is a pointer to a message in the canned notes file.
  (For more information see page 43)
- An expected $ reimbursement was added to the fee schedule in the CPT codes. If the expected $ is set and the flag that turns on the checking feature is set, Quick-MD will tell the operator during payment posting if the payment is short of what is expected. The check box is in Properties/Misc Defaults/Other defaults.
  (For more information see page 44)
- Everywhere in the system that addresses the Prior Auth number it has been expanded from 15 to 20 characters.
  (For more information see page 190)
- A check box to ignore secondary claims was added to the LA electronic Medicaid filing.
  The operator was added to all ledger notes.
  (For more information see page 162)
- The Co-payments amounts were added to the charge entry screen.
  (For more information see page 163)
- In Q-Schedule, the **<F11>** key will apply the current template to the day.
  (For more information see page 105)
- In Q-Schedule, under the “Settings” button a new check box was added, “Apply template to existing days”. If checked Q-Schedule will automatically apply any new template to all future days as long as no appointments have been booked on that date.
  (For more information see page 105)
- The cut & paste will move the red or blocked slots under the appointment and restore the current template to the cut area of the day.
  (For more information see page 108)
- The search for next available appointment will now put a date and time in a question box. If the operator clicks no then the search will continue.
  (For more information see page 112)
- A new check box called “Stop Book” was added to the patient demographics screen in the lower right hand corner. If it is checked the enhanced appoint system will block the operator from booking this patient.
- The amount of payments for the date of last payments on the balances screen will now have the total of the payments for that date.
  (For more information see page 182)
- A new check box was added to “Charge Entry Options” that will allow the system to not add charges to last claim if the last claim has the “P” responsibility on it.
  (For more information see page 80)
- A backup path for electronic claims files was added to the Clearing House Electronic settings. All electronic ANSI files will be backed up to this path instead of to the floppy drive.
- You can now filter the ledger to show only claims that patient’s are responsible for. You can filter out all insurance claims by now hitting <Shift>+<F5A>.
  (For more information see page 172)

- A group code was added to the operator rights screen. This allows you to group users together by a one character code so that e-mails can be sent to groups of people, such as front desk staff or Billing clerks.

- A Quick-MD startup monitor resolution was added to properties/misc defaults/ other defaults. If set the system will change the windows monitor resolution to the selected resolution when Quick-MD is started. When Quick-Md is exited the resolution will be changed back to what it was before starting Quick-MD.

- HIPAA notice & Pending insurance balance was added to the Patient Statement settings in properties. The pending insurance balance is calculated by the following rules; If the claim has a balance and the “P” responsibility is not on the claim, then the balance of the claim is summed into the pending Ins. Balance.

- In Properties/Misc. defaults a new check box was added. Put only balance forward on patient statements. If checked only a balance forward will appear on the patient statement and not the charges forward and the credits forward.

- Third party export was added to the enhanced scheduler. You can now export a file to use with Televox’s automated appointment calling system.

Version 4.4

- An additional field that allows you to search by Date of Birth has been added to the patient lookup screen.
  (For more information see page 211)
- Quick-MD is now integrated with the following Electronic Medical Records packages: Mednotes, Medinotes, Medamation, SOAPware and Pacific Voice Products.
- You can now default the cursor in supply form to the prior Auth#
  (For more information see page 80)
- A cancel button was added to the patient's insurance screens.
- When pulling a PO# from the managed care module into the supply form the System now checks the date range to the service date of the charge. When pulling it into an appointment it now checks the date range against the date Of the appointment.
- The operator that created the patient file will be shown in the lower right corner Of the patient demographics screen. All the patients entered before V4.4 will be Defaulted to operator #1.
- You can default the prior Auth# in managed care module to the previous number by pressing the **<F1>** key.
  (For more information see page 190)
- Super bill printed checkbox was added to the enhanced appointment system. When checked it will put a $ in front of patient name.
- Last CPT code entered in the patient's ledger was added to the super bill print. Beginning and ending session dates was added to the super bill print.
  (For more information see page 115)

Version 4.3

- Historical secondary insurance information was added. To force a use secondary company put the **&** symbol in the comment filed followed by the company ID#.
  (For more information see page 154)
- A new payment posting module was added. It will post payments by line Item and will allow you to use un-applied credits. This module can be used for both patient and insurance payment posting.
  (For more information see page 231)
- The Paper forms batch billing modules have a check box that will allow you to run a pre-billing report before printing the paper claims.
  (For more information see pages 219,221,221)
- The Brief Ageing report can be narrowed to patient responsible balances only.
  (For more information see page 256)
- The Current Ledger Browse Window can be narrowed to 1 claim by pressing <Shift> + **<F2>** and entering a claim number. To see the entire ledger again, enter a zero.
  (For more information see page 172)
- A check box to default the cursor in the company ID# field of the patient Statement window was added to the Properties/Misc. Defaults/Other Defaults Screen.
  (For more information see page 98)
- You can now exclude financial classes on the paper insurance batch billing.
  (For more information see page 216)
- The check for duplicate patient on the name & SS# will now show all patients that match the name or SS# and will show their financial class on the duplicate Patient information window.
  (For more information see page 150)
- Re-Bill un-paid insurance claims module was added to the batch billing menu.
  (For more information see page 222)
- A new address labels module was added on the reports menu. Before using it the coordinates must be set in properties. It will allow you to print single tractor feed labels or 1" X 4" labels that come on an 8" X 11" sheet Of 20 labels.
  (For more information see page 255)

- <Shift> + <F4> in the Current Ledger Browse Screen will toggle the ledger to zero & Non-zero balance claims. *(For more information see page 172).* A default for this was added to the browser defaults in properties. *(For more information see page 76)*
- The Search for a existing patient appointment now has buttons to search 30,60,90,180, and year out. *(for more information see page 110)*
- Generation was added to the patient demographics screen. When filled out The generation will be sent in all electronic claims transmissions. *(For more information see page 147)*
- A new report was added to the report menu. Financial class ageing summary. *(for more information see page 263)*
- You can now set the default on the new appointment system status code. This Is done in the settings screen. *(for more information see page 114)*
- Dispense, Sig, and Print without DEA number was added to prescriptions. *(for more information see page 208)*
- Primary, Secondary, and Third Ins. Copay was added to the Inter-Office Message box. *(for more information see page 159)*
- In the enhanced appointment system. A time range to search for future Appointments was added. *(for more information see page 114)*
- Default referring Phy. Was added to the provider table. *(for more information see page 65)*
- For all reports that are over 80 columns a landscape check box was added To the report screens.
- A new report was added to the Recap menu. It will summarize your Daily recaps for a span of up to two years. *(For more information see page 245)*
- In the mail merge module the ability to merge just patient or insurance Balances was added. *(For more information see page 253)*
- F1-See More was added to the referring Phy. Browse screen.

Version 4.2

- Managed Care Module was added.
  (For more information see page 187)
- Default area code was added.
  (For more information see page 72)
- You can now exclude payments & adjustments when filing claims.
  (For more information see page 154)
- A payment entry screen was added to the charge entry screen. It will allow the Operator to auto apply patient credits to charges.
  (For more information on Un-Applied credits see page 187)
- Shift-F3 will make a billing note a regular note. So now you can re-bill Claims without deleting the billing note and instead turning it into a Regular note.
  (For more information see page172)
- Report on last batch billing run and delete billing notes for last batch billing Run was added to the billing menu.
  (For more information see page222)
- In misc. defaults a check box was added that will allow the providers name To print in block 33 along with the office name and address.
  (For more information see page98)
- TPL number was added when Medicaid is secondary to a private Ins.
  (For more information see page 154)
- Appointment audit report was added to Q-Schedule.
  (For more information see page 112)
- Diagnosis codes can be removed from patient receipt.
  (For more information see page 98)

VERSION 4.1

- Quick-MD now keeps track of all deleted ledger records except Notes.
  There is a report in System Utilities that will allow you to report on
  The deleted entries.
  (For more information see page 293)

VERSION 4.0

- The delete billing notes function now gives you the ability to narrow to one Ins. Company.
  (For more information see page291)

- You can now use templates for other documents in the Medical Records Interface.
  (For more information see page202)
- The balances screen now lists the Referring Physician. That was set on the last claim in the Patient's ledger.
  (For more information see page 182)
- You can now exclude financial classes from the Brief Ageing Report, Detailed Ageing Report, and the Collection Work Report.
  (For more information see pages 256, 257, 263)
- A Custom Information screen was added to the patient file.
  (For more information see page 182)
- There is now a check box on the clearing house initial run screen, that if checked will Only pick up claims for companies that have a clearing house ID# set in the insurance Record.
  (For more information see page 227)
- During the charge entry process, Quick-MD will now check to make sure all diagnosis attached to the charge are set in the patient's diagnosis table.
  (For more information see page 163)

VERSION 3.9

- Inner Office E-Mail was added, you can also e-mail patient notes.
  (For more information see page 295)
- Recurring Charges & Payments Module was added in System Utilities.
  (For more information see page 292)
- "Have not visited since date of" was added to patient file query report.
  (For more information see page 247)
- The ability to narrow recall report to one type of recall was added.
  (For more information see page 279)
- CPT codes report can now be narrowed to a range of codes.
  (For more information see page 268)
- Inner-Office E-Mail system was added to Q-Schedule.
  (For more information see page 105)
- A 4 column appointment listing report was added to Q-Schedule. Check the 4 column listing box in settings to activate.
  (For more information see page 109)
- Insurance Table records have a check box to use SS# in block 25 for companies that want the providers SS# instead of the tax ID# in that block.
  (For more information see page 55)
- You can now put SS number on super bill in the New Appointment system.
  (For more information see page 154)

- A 2 character Credentials field was added to the provider table.
  (For more information see page 65)
- You can now add secondary and third billing notes from quick payment posting Modules ledger browse screens. Add screen to manual
  (For more information see page 154)
- You can now edit operator & location on the edit screens of charges, Payments, and adjustments.
  (For more information see page 154)

VERSION 3.8

- Medical Records Interface
  (For more information see page 193)
- Phone Messages
  (For more information see page 205)
- Prescription Information
  (For more information see page 208)
- Extension for work phone in patient file was added.
  (For more information see page 147)
- Orphan ledger search utility was added to System Utilities.
  (For more information see page 294)
- You can block billing to patient for just one claim with the “P” responsibility On it by adding a note to the claim with BLOCK PATIENT! on the Description line.
  (For more information see page 154)
- A new report was added (Collections Work Report)
  (For more information see page 263)
- A check box to default services dates in charge entry screen was added to Misc. Defaults screen.
  (For more information see page 91)
- Fax number was added to Ref.Phy. File.
  (For more information see page 49)
- Guarantor was added to patient file query report on the select by parameters.
  (For more information see page 247)
- You can now set colors in the appointment reasons by placing [A],[R],[G],[S],[B], or [Y] at the end of the reason line. The amount of time to reserve for the appointment can be set by placing {2},{3},[4} {5}, or {6} at the end of the reason line.
  (For more information see page 115)
- Patient’s address was added to the Q-Schedule more information screen, And may be edited from the patient’s name field if the patient ID# is set.
  (For more information see page 107)
- Search for future appointments was added to Q-Schedule and the Standard Appointment System.
  (For more information see page 105)
- A check box “Allow user to enter ledgers” was added to operator rights.
  (For more information see page 286)
- Electronic Remittance now browses the folder set in the path setting for the remittance file to report or download to payment posting modules. The download will go into the line item posting module if the checkbox “Line item posting” is checked in the remittance settings screen in properties.
  (For more information see page 103)

VERSION 3.7

- 5 more extra ID#’s added to provider records.
  (For more information see page 65)

- Insurance class codes added to insurance file & ability to set 10 class ID#'s in provider record.
  (For more information see page 55)
- Patient balance aging in reports & billing in based on a new date set in charges, "Date patient responsibility is set" . The system auto sets the date when charges are entered with the "P" responsibility or when you re-assign to the "P". If the date is not set then aging is based on the service date.

- A new report was added to the enhanced scheduler. List appointments for a period.
  (For more information see page 109)
- You can now disable the standard appointment system. In properties/Misc. defaults there is a check box to enable/disable.
  (For more information see page 91)
- A new report was added to the new appointment system. "Referring Phy. Report."
  (For more information see page 112)
- The Download in the Data Output processor was changed to download the text File to the path & filename of the word processing path in properties/Misc. Defaults.
  (For more information see page 160)
- Birthday listing by month was added to Patient File Query report.
  (For more information see page 247)
- All Recap reports can now be run in ID# or Alpha order.
  (For more information see page 242)
- Line Item Payment Posting Module was added.
- Electronic remittance can be set to download to line item posting.
- In electronic remittance properties, the path should now be set Only to the folder that the remit files are down loaded to and not Include the file name. When you press the report or download Button in the remittance module the folder browse dialog will Appear and you select the appropriate file name.
  (For more information see page 103)

VERSION 3.6

- You may have up to 3 additional primary Ins. Companies and Quick-MD can be set to automatically decide which company to use when filing a claim, or the company can be indicated on one of the charges of the claim.
  (For more information see page 153)
- For DME billing you can set the provider's DME number and define the DME company to Quick-MD and will place the number in block 33 and the reserved column of the charges.

  (For more information see page 65)
- Many reports can now be run by By Date Of Service and also by the ledger date.
  (For more information see page 247)
- The Mail Merge report has the ability to select by date of birth before and after. It also can be run by diagnosis code.
  (For more information see page 253)
- New appointment system added that will book 4 slots per provider
  (For more information see page 105)
  The mouse wheel will now scroll the time slot screen in Q-Schedule. It will also scroll the Data Output Processor Screen.
  (For more information see page 106 and 160)

VERSION 3.5

- Appointment system templates for each provider for each day was added. You must have the new file APTEMP.DAT for this to work. Make sure

this file is put on your system and check the Use Appointment Templates box in the Misc. Defaults screen in properties.
(For more information see page 119)

- There are new check boxes in Misc. Defaults that will stop the provider Tax Id and Government Provider Ins numbers from printing on receipts and itemized statements.
  (For more information see page 91)
- A check box has been added in Misc. Defaults that will stop Invoices priced at $0.00 or less from billing billed in all Ins billing.
  (For more information see page 91)

Version 3.4

- CPT Codes fee schedule expanded to 25 companies.
  (For more information see page 44)
- When posting payments in ledgers you can now set ask about write offs.
  (For more information see page 91)
- Four more colors were added to appointment system's time slots.
  (For more information see page 105)
- Cut & Paste appointments with a double click on patient's name.
  (For more information see page 108)
- Fixed dollar patient co-percent billing was added.
  (For more information see page 183)
- A new blocked bills report was added
  (For more information see page 281)
- A second Medicare company ID can be defined in Insurance ID# table.
  (For more information see page 55)
- The first 4 diagnosis's and medical record number can be put on super bill.
  (For more information see page 114)
- You can set insurance company records inactive.
  (For more information see page 55)
- Ask about reassignments check box was added to misc. defaults.
  (For more information see page 91)
- A CPT codes modifier table was added to properties.
  (For more information see page 84)
- Open patient ledger was added to the File menu. This will take the operator directly to the patient's ledger from the look up screen.
  (For more information see page 214)
- In Miscellaneous Defaults, A check box was added that will display the service date on the ledger browse screen.
  (For more information see page 91)
- You can now set a refresh for the appointment screen in Misc. Defaults. If checked it will refresh the screen about every 10 seconds when a day is open.
  (For more information see page 91)
- A check box has been added to the insurance company records that will block all claims for that company from being sent to the clearing house.
  (For more information see page 55)
- An invoice billing system for companies has been developed that will bill companies that are setup in the statement box of the patient file. An associated check box was added to misc. defaults screen to support this new utility.
  (For more information see page 91)

Version 3.1 to 3.3

- Number super bills
  (for more information see page 117)

- You can type SS in the policy # data field to auto put SS#
  (for more information see page 151)
- You can type zip code in all city data fields in patient files
  (For more information see page 147)
- On the super bill you can now define date of last payment and ledger balance.
  (For more information see page 115)
- Invoice balance on ledger browse screen.
  (For more information see page 172)
- Two additional sort codes were added for enhanced patient reporting
- Electronic patient statements
  (For more information see page 216)
- Canned Notes has now been added
  (For more information see page 289)
- A new checkbox in Misc. Defaults will allow you to put a balance forward on receipts
  (For more information see page 91)
- Each operator now has there own Insurance payment posting file.
  Patient payment posting module can pickup any balance & now be used for
  Insurance payment posting.
  (For more information see page 231)
- Each operator now has there own insurance posting file in the insurance posting module.

- The **<F7>** key on the appointment screen will print a super bill for 1 patient

- New ageing report that list balances by insurance companies in alpha order.
  (For more information see page 261)
- More totals have been added to the patient ledger balance screen.
  (For more information see page 182)
- You can set default sex, provider, and financial class for patient file creation.
  (For more information see page 72)
- In operator rights the deletions can be set for each type of ledger entry.
  (For more information see page 286)
- Check Box in CPT records to set them in-active & warn operator.
  (For more information see page 46)
- You can set a flag that will make the CPT code appear in front of the description
  on charge entry.
  (For more information see page 91)
- When adding notes to ledger, you can add up to 5 notes at one time.
  (For more information see page 162)
- Paper insurance batch billing can be done in alpha, ID#, or primary ins. order.
  (For more information see page 219, 221, 221)
- Automatic dunning notices for over 30,60,90,120 days on patient statements.
  (For more information see page 77)
- Second office address with check boxes that allow you to use either address
  for patient billing and insurance billing.
  (For more information see page 63)
- Charges can now be excluded to stop the charge from being
  billed on the 1500 form or electronically.
  (For more information see page 172)
- On patient statement batch billing you can enter a date that will stop billing
  on all patients that have been billed on or after the entered date.
  (For more information see page 216)

FEATURES, FUNCTIONS AND CONCEPTS

Quick-MD is an extremely powerful and flexible system that can be tailored to match the needs and workflow of any medical practice. As you work with the program you will find that it is both intuitive and logically laid out. This section describes some key features, functions and concepts that you should be familiar with before you begin setting up and using your new system.

A Word or Two on Navigation

Although Quick-MD is a true windows application and you can use your mouse to navigate menus and make selections, the system was designed so that you can navigate Quick-MD entirely from the keyboard. This dramatically speeds up your ability to both enter and retrieve information.

<Enter> – It is not necessary to use the **<Tab>** button to move your cursor from field to field when entering information into Quick-MD's various screens, although you can certainly still do so if you wish. Quick-MD allows the use of the **<Enter>** button to move from field to field when entering information. This was done to imitate the Unix character based systems, which do allow for faster data entry than using a mouse to Navigate windows.

<Tab> - Moves your cursor from field to field when you are entering information into the various screens of the program.

<Shift> + <Tab> - returns cursor to previous field.

<Alt> + <Underlined Letter> - Many of the menu's in Quick-MD contain an Underlined letter. Holding down the **<Alt>** key and selecting the **<Underlined Letter>** performs the function of that button without the user having to take their hands off the keyboard.

***Note:** Users who learn to use the **<Alt>** keys will be much faster than those who rely on the mouse.*

<Hot Keys> - The key that is hot has a dotted line around it. The enter key will activate the key that is hot. Also the up and down, left and right arrow keys on the keyboard will move the hot key in the desired Direction. Once the desired function key becomes hot, simply press the enter key. This is a very fast way of utilizing Quick-MD's features!

<Esc> Key- There is never a reason to use the **X** at the top right of each screen. This means abort and you will lose any changes you have made. If there is not a **Save** or **Exit** button then the **<Esc>** key allows you to exit windows.

<F12> Key – Opens the Standard Scheduler from anywhere in the patient's demographics or ledger and allow the user to return to his original spot when finished scheduling.

Online Help

Each screen in Quick-MD will have a button with a red question mark on it; this is a help button. Clicking on a help button will start a tutorial explaining the uses and concepts of that particular feature. *(for more information see page 301)*

Yellow Fields

While using Quick-MD you will notice that many fields on the various screens are colored with a yellow background. Yellow Fields are special fields that allow you to either browse the information from a table **<F1>** or add information **<F10>** directly to that table if it is not yet setup. The two keys that you have to remember to use in the Yellow Fields are:

<F1> - Allows the user to browse that table to lookup information.

<F10> - Allows user to add to entries directly to any of the four main tables in Quick-MD on the fly. These tables are the **ICDM Table** *(for more information see page 39)*, **CPT Code Table** *(for more information see page 43)*, **Insurance Companies Table** *(for more information see page 55*) , and the **Referring Physician Tables** *(for more information see page 49)* ,.

RESPONSIBILITY CODES

Quick-MD uses Responsibility Codes to define to the system who is responsible for a claim's balance.

***IMPORTANT:** IT IS IMPOSSIBLE TO USE QUICK-MD WITHOUT A THOROUGH UNDERSTANDING OF THE RESPOSIBILTY CODES!*

The four responsibility codes are:

I = Primary Insurance
S = Secondary Insurance
A = Third Insurance
P = Patient Responsibility

A claim, which may have multiple invoices (or line item "charges"), can only have ONE responsibility at a time. Think of a claim as a charge, or a group of charges, on a 1500 form. Obviously, only one party at a time can be responsible for this one 1500 form. Once the responsible party has paid their portion of the claim, then you can reassign the balance to another party. But again, there is only ONE party responsible for the claim at this time. This process of accepting payments and reassigning responsibility happens as many times as necessary until the claim eventually either comes to a zero balance or is written off.

Each invoice (or line item charge) carries a responsibility code that was assigned during the **CHARGE ENTRY** process. This defines to Quick-MD who is currently responsible for that balance. Remember that it is only the charges on a claim that determine responsibilities. You can have payments and adjustments from various sources other than the responsible party, you are only looking at the responsibility codes of the charges to determine who the responsible party is.

Once the payer (for this original responsibility) has paid and you wish to re-assign the balance to either secondary, third insurance or the patient, simply place the additional responsibility code to any "one" of the invoices (charges) within a claim, and the whole claim is then reassigned. All other charges in the claim will inherit the new responsibility. In other words, you only have to change the responsibility of one of the charges (invoices) within a claim, to tell the system to bill the next responsible party for the remaining claim balance.

Should the payer pay one or more of the invoices (charges), but deny one or more of the invoices (charges), and you wish to reassign the ones paid to the next payer and to re-bill the ones denied to the same responsible party, it will be necessary to start a new claim with the ones to be re-billed. This will allow the responsibility to remain the same on the new claim and allow you to reassign the ones paid to the new responsibility. This is currently done by going to the ledger for this patient. When the ledger opens up, it opens to the last claim. Make a note of the last claim number. Highlight the claim you wish to re-bill (leaving the responsibility the same) and hit F4 to edit. When the edit screen pops up, simply go to the Claim field and assign it the next available claim number. Change the Invoice number to Invoice number one. Do this for all invoices that you wish to remain at this responsibility code. Keep in mind they will all carry the same Claim number, but each one will receive the next available Invoice number.

Additionally, the system will ask for a responsibility code when posting a payment. The responsibility code that applies to the payer making the payment should be entered at this time. Remember, it is only charges, not payments or adjustments, that determine the responsibility of the claim as a whole.

FOR LOUISIANA KIDMED USERS ONLY

For clients in La. that wish to file their claims direct to Kid Med you will first have to make application with them and secure a submitter ID#. You will then go to Properties/Electronic filing/Electronic Ochsner/Kidmed Settings and setup the submitter id and the file name. You will need to create a directory on either your server drive or the local hard drive of the machine transmitting the claims called "ebill". Put the following, in the field labeled "Path to communications directory" under Properties/Electronic filing/Electronic Ochsner/Kidmed Settings, c:\ebill\H450???.kid. (if you created a folder on your server drive use it's name in place of c:\ebill)

Next, you will need to create a Kid Med insurance company in the master insurance table. You can do this by going to tables/Add Insurance Record. Remember the id of the insurance company that you just created, then go to

Properties/Insurance Id Numbers, in the field labeled “Your Kid Med ID# From the Insurance File” put in the Kid Med ID#.

When setting up a patient’s account, the Kid Med insurance company must be defined as the patient’s third insurance company. Any Kid Med charges entered will need to have the responsibility of ‘A’. After entering a Kid Med claim, the electronic version of the KM3 form will be displayed, if you need to access the KM3 form after the claim is entered go to the current ledger, highlight a Kid Med claim, and hit the shift-F8 key combination.

Billing Notes

Quick-MD puts a red billing note in the ledger when a claim is billed and shows the user whether it’s a Primary Insurance (1000), Secondary Insurance (1001), Third (1002) or Patient Billing (1003) note. When Quick-MD is told to bill a particular Responsibility Code, it runs through all the ledgers checking for claims that have no billing notes on them.

It is very important to understand this concept!

Payment Posting

ALWAYS post payments and adjustment to the individual claim that you are receiving payment on. All claims eventually come to a zero balance once payments and adjustments have been appropriately applied. NEVER post all payments and adjustments to only one claim in a patient’s ledger, as this will leave one claim with a credit balance and all other claims with balances owed. If you are going to be filling **secondary claims** electronically to THIN or Medicare you **must pos**t you payments by **line item**.

Ledger Date

All daily recaps use the ledger date and NOT the date of service for reporting. The Ageing Reports will give you the option of running them either by ledger date or date of service.

Date Fields

You never have to enter the current year in Quick-MD. Leaving any year field blank will automatically cause the system to enter the current year. Additionally, you never have to enter today’s date in Quick-MD. Simply type a “9” in any date field to have the system place today’s date in the field for you.

QUICK-REFERENCE – A TYPICAL DAY IN THE OFFICE

This Quick-Reference walks you through the various features of Quick-MD that would be used over the course of a typical day in the office.

SCHEDULING QUICK-REFERENCE – USING Q-SCHEDULE

Q-Schedule is a separate, but integrated, application that is started from its own icon. When open, this Scheduler operates on a separate tab on the tool bar, which allows for access to it while working anywhere in Quick-MD or any other program. *(for detailed information on using Q-Schedule see page 105)*

FUNCTION KEYS USED IN Q-SCHEDULE

<F1> or <Double-Click> – Opens the Patient Booking Screen
<F2> - View appointment information for the selected time slot.
<F3> - make the selected time slot Red
<F4> - make the selected time slot Green
<F5> - make the selected time slot Blue
<F6> - make the selected time slot Yellow
<F7> - make the selected time slot Silver
<F8> - print a Super Bill for the selected time slot
<F9> - block entire day

SCHEDULING AN APPOINTMENT

(for detailed information about Scheduling an Appointment see page 107)

1. Select the Provider you wish to book an appointment for to display their appointment book(s)
2. Use the Calendar to select the day you wish to book the appointment on. Then choose a time slot from the available appointment books.
   ***NOTE:** You can also Search for next available appointment by hitting the **NEXT. AV.** Button on the menu bar.*
3. Hit **<F1>** or **<DOUBLE CLICK>** to open the Booking Screen.
4. Enter the Patient's Name for new patients, or if you are booking for an existing patient hit **<F1>** to browse for the appropriate patient.
5. Complete Booking Screen Information
6. Hit **<OK>** to schedule the appointment.

DELETING AN APPOINTMENT

1. Select the Appointment you wish to delete.
2. Hit **<F1>** or **<DOUBLE CLICK>** to open the Booking Screen.
3. Hit the **<CANCEL>** button.
4. Quick-MD will ask you if you want to delete this appointment, select **<Yes>.**

MOVING AN APPOINTMENT

1. Select the Appointment you wish to move.
2. Hit **<F1>** or **<DOUBLE CLICK>** to open the Booking Screen.
3. Hit the **<CUT>** button.
4. Quick-MD will ask you if you want to cut this appointment, select **<Yes>**.
5. Select the time slot you wish to move the appointment to.
6. Hit **<F1>** or **<DOUBLE CLICK>** to open the Booking Screen.
7. Hit the **<PASTE>** button.
8. Quick-MD will ask you if you want to paste this appointment, select **<Yes>**.

VERIFYING APPOINTMENTS

You can easily see which appointments have been verified or not from within the scheduler. Verified appointments will have an * before the name of the patient. To mark an appointment as verified, follow these steps.

1. Select the Appointment you wish to verify.
2. Hit **<F1>** or **<DOUBLE CLICK>** to open the Booking Screen.

3. Click the button next to the Verified Field.
4. This appointment will now be preceded by an * when viewed in the scheduler.

Printing Super Bills

Super Bills can be printed in batches by a date or individually as needed.

- To print a batch of Super Bills for an entire day, go to the **Reports** menu and select **Print Super Bills**. Enter the date you wish to print Super Bills for.
- To print an individual Super Bill, put your cursor in the timeslot of the appointment for which you want the Super Bill printed and hit the **<F8>** key.

Reports

The reports menu allows you to gather information about your appointments and other related material.

- **Appointment Listing** – prints an appointment listing for a specific day.
- **Appointment Listing for a period** – prints an appointment listing for a specified date range.
- **Print Super Bills** – Prints a batch of Super Bills for all patients scheduled for a specified date.
- **Search for Existing Appointment** – Queries the scheduler for an existing appointment.
- **Query Appointments** – Allows you to search for appointments based on specified criteria
- **Referring Physician Report** – prints a report of who referred your patients to you by a specified date range
- **Appointment Audit Report** – generates a report by a specified date that shows which patients showed up for their appointments and whether or not charges where entered for this patient on that day.

Scheduling Quick-Reference – Using Multi-View Scheduler

The Multi-View Scheduler is a separate, but integrated, application that is started from its own icon. When open, this Multi-View Scheduler operates on a separate tab on the tool bar, which allows for access to it while working anywhere in Quick-MD or any other program. *(for detailed information on using the Multi-view Scheduler see page 124)*

Function Keys used in the Multi-View Scheduler

<F2> - View appointment information for the selected time slot.
<F3> - Make the selected time slot Red.
<F8> - Print a Super Bill for the selected time slot.
<F9> - Block fields for a time period.
<F11> - Apply a template to the current day.

Scheduling an Appointment

(for detailed information about scheduling an Appointment see page 124)

1. Use the calendar to select the day you wish to book the appointment on. Then choose a time slot from the available appointment books. ***Note:*** *You can also search for the next available appointment by hitting the **Next Available** button at the top of the form.*
2. **<Double Click>** to open the booking screen.
3. Enter the Patient's name for new patients, or if you are booking for an existing patient hit **<F1>** to browse for the appropriate patient.
4. Complete booking screen information.
5. Hit **<OK>** to schedule the appointment.

Deleting an appointment

1. Select the Appointment you wish to delete
2. **<Double Click>** to open the Booking Screen.
3. Hit the **<Cancel>** button.
4. Quick-MD will ask you if you want to delete this appointment, select **<Yes>**.

Moving an appointment

1. Select the appointment you wish to move.

2. **<Double Click>** to open the booking screen
3. Hit the **<Cut>** Button.
4. Quick-MD will ask you if you want to cut this appointment, select **<Yes>**
5. Select the slot you wish to move the appointment to.
6. **<Double click>** to open the booking screen
7. Hit the **<Paste>**button
8. Quick-MD will ask you if you want to paste this appointment, select **<Yes>**.

Verifying Appointments

You can easily see which appointments have been verified or not from within the scheduler. Verified appointments will have an * before the name of the patient. To mark an appointment as verified, follow these steps.

1. Select the Appointment you wish to verify.
2. **<Double Click>** to open the booking screen.
3. Click the button next to the verified field.
4. This appointment will now be preceded by an * when viewed in the scheduler.

Waiting List

Adding a patient to the waiting list

1. **<Double click>** on the time slot that you want to book this appointment for.
2. Add the information to the booking screen.
3. Click on the **<Put on W.List>** button.
4. The system will ask you if you want to add this patient to the waiting list. Click **<Yes>**.
5. Click **<OK>** on the waiting list screen.
6. Click **<OK>** on the Booking Screen.

Booking a patient from the waiting list

1. **<Double Click>** on the time slot where you want to book the appointment.
2. On the booking screen click on the button **<Waiting List>**
3. Click the **<BK>** button next to the appointment that you want to book.
4. Confirm the dialog boxes by clicking **<OK>** and **<Yes>**
5. Click **<OK>** on the booking screen.

Printing Super Bills

Super bills can be printed in batches by a date or individually as needed.

- To print a batch of super bills for an entire day, go to the reports menu and select **Batch Print Super Bills**. Enter the date you wish to print super bills for.
- To print an individual super bill, put your cursor in the timeslot of the appointment for which you want the super bill printed and hit the **<F8>** key.

Reports

The reports menu allows you to gather information about your appointments and other related material.

- **List Appointments for a day** – Prints an appointment listing for a specific day.
- **List appointments Combined** – Lets you print a daily appointment listing for multiple providers.
- **Batch Print Super Bills** – Prints a batch of super bills for all patients scheduled for a specified date.
- **Query appointment status codes** – Allows you to search for appointments using their status code.
- **Referring Physician Report** – prints a report of who referred your patients to you by a specified date range.
- **Appointment Audit Report** – generates a report by a specified date that show which patients showed up for their appointments and whether or not charges where entered for this patient on that day.
- **Third Party Export** – Export you appointment listing for a day to be used by software provided by a third party.

Patient Quick-Reference - Working With Patients

(for detailed information about Working with Patients see page 124)

Entering New Patients

Getting there:

From Quick-MD's front screen click the **<File>** menu, then select **<Add New Patient File>**. Or from the Quick-MD front screen, click the  icon.

Once the Patient Demographic screen appears, you can begin to enter the patient's information. Remember that the **<Enter>** key allows you to move from field to field. Once the **<Save>** button has been clicked, the **[Primary Insurance Button]** will become activated so you can move right on to setting up the patients insurance.

Looking Up Patients

Getting there:

From Quick-MD's front screen click the **<File>** menu, then select **<Lookup Patient>**. Or from the Quick-MD front screen, click the  icon.

Once the "Patient Browse Screen" appears, you can search by ID, SS#, Medical Record#, Last Name or first name. You can also search by a partial first name by entering as many characters of the name as you know into the "Medical Records" field.

Entering Charges

(for detailed information on Entering Charges see page 163)

Charges are either entered as each patient leaves the office (checking out patients) or are done in batches at a later time. Either way, they are done in the same way, via the Charge Entry Screen.

***Getting There**:*

*In any Patient Demographic Screen, click on the **<Ledger>** button and then click either **<Enter Charges New Claim>**, **< Enter Charges Patient Claim>** or **< Enter Charges Last Claim>**.*

*You can also get to this screen from the File Menu by selecting <**File>** then < **Fast Charge Entry>**.*

The **Charge Entry Screen** is a multi-screen form that flows in such a manner that you can easily enter all the necessary information needed to complete a HCFA 1500 form in the most efficient manner possible. The flow of using the charge entry screen is as follows:

1. Enter CPT Code for charge
2. Enter up to 4 diagnosis codes for the charge
3. Provide Other Information pertaining to the charge
4. Repeat above steps for each new charge to be added to claim
5. Once all charges are entered, enter the necessary supply record information.

Working in the Patient's Ledger

(for detailed information about the Patient's Ledger see page 172)

Function Keys used in the Patient's Ledger

<F1> - Pay – Used to apply a payment to the highlighted "charge" in the ledger
<F2>- Adj – Used to apply a adjustment to the highlighted "charge" in the ledger
<F3> - Note – Used to post a note to the highlighted claim
<F4> - Edit – Used to Edit the highlighted charge, payment, adjustment, or note
<F5> - Reassign – Used to apply a reassign to the highlighted claim in the ledger
<F6> - ClmBal – Will populate the Invoice and Total fields at the bottom of the ledger with the balances for the highlighted claim.

<F7> - LEDBAL - Will populate the Ins$ and Pat$ fields at the bottom of the ledger with the insurance and patient balances for this patient.
<F8> - SUPPLY – Brings up the Supplier Screen to view the supplier information for this claim.
<F9> - PRINTS - Allows you to print an Individual HCFA form for this claim. Also allows you to print a patient statement and a itemized claim to be used as a patient receipt.
<F10> - DELETE – deletes the highlighted entry
<F11> - EXCLUDE - Used to exclude a charge from being included when re-billing a claim
<SHIFT> + <F3> - CONVERT NOTE- Used to convert a red billing note to a regular note so that the claim can be re-billed while retaining an audit trail of previous activity.
<SHIFT> + <F2> - BROWSE 1 CLAIM- Used to filter the ledger to display only the desired claim
<SHIFT> + <F4> - TOGGLE ZERO CLAIMS- Used to hide all claims with a zero balance
<SHIFT> + <F5> - ONLY P CLAIMS- Used to show only patient responsible claims.

DELETING PATIENTS

Getting there:
From Quick-MD's front screen click the **<File>** menu, then select **<Delete Patient File>**.

RECAPPING TRANSACTIONS QUICK-REFERENCE - DAILY RECAPS

(for detailed information about Recapping Transactions see page 242)

All daily totals are reported via the **<Recaps>** menu located on Quick-MD's front screen. You can select a "Daily Recap" which reports all charges, adjustments and payments for a day in one report or run reports on just, charges, adjustments or payments for a day.



Each of these reports can be narrowed down by "operator".
(For more information see "Recapping Transactions for a Day" on page 242)

BILLING QUICK-REFERENCE

(for detailed information about Billing in Quick-MD see page 216)

HOW QUICK-MD BILLS

Quick-MD will go through all patient ledgers and look for claims with balances owed for the chosen responsibility code. If there is no red billing note on the claim and the claim has a balance owed, then it will be picked up for billing.

Whenever an insurance company or the patient is billed, Quick-MD will place a notation entry in the patient's ledger saying who was billed, when they were billed, and the amount of the bill. These billing notations also have their own invoice numbers. A primary insurance billing notation will have an invoice number of 1000, a secondary insurance billing notation will have an invoice number of 1001, a third insurance billing notation will have an invoice number of 1002, and a patient billing notation will have an invoice number of 1003. Do

not delete these invoices. Quick-MD uses them to determine if the responsible parties listed on the claim have been billed.

Quick-MD will consider the claim paid when there is a zero balance on the claim. All claims must reach a zero balance at some time, whether by payment or write off, so post all payments and adjustments to the claim they are intended to pay or adjust.

Batch Billing Paper Claims

(for detailed information about Batch Billing Paper Claims see page 216)

All batch billing of paper claims is done via the "Billing" Menu located on Quick-MD's front screen. From here you can batch bill patient statements both on paper and electronically. You can also batch bill paper claims for Primary, Secondary and Third Insurance Companies. You can also re-bill the last batch printed and delete billing notes for the last batch printed.

Batch Billing Electronic Claims

(for detailed information about Batch Billing Electronic Claims see page 223)

All batch billing of electronic claims is done via the "Ebill" Menu located on Quick-MD's front screen. The procedure is:

1. Select the company you wish to bill for.
2. Select **<Initial Run>.**
3. Once the report has been brought to the screen, click the **<End>** button to scroll to the bottom of the report. If the report says "**** NO ERRORS FOUND - BATCH READY FOR TRANSMISSION ****" then proceed to step 7, if the report says **** ERRORS FOUND - BATCH NOT READY FOR TRANSMISSION **** then proceed on to step 4.
4. Click Repeat Billing Run, this will only pull out the claims with errors.
5. Print the error report and correct each of the problems.
6. Continue re-running the Repeat Initial Run until the report is empty, meaning there are no more errors in the batch.
7. Click **<Live Billing Run>.**
8. If you want to remove a claim from this billing batch, click **<Remove Claim from Run>**.
9. If you wish to save a backup of this billing batch, click **<Copy Last Run to Disk>.**
10. To read the response file from your last transmission, click **<Read Response File>**.

Printing an Individual HCFA 1500 form

1. Open the desired Patient's Ledger.
2. Select the claim you wish to print the HCFA for.
3. Hit **<F9>** to bring up the print window
4. Choose the appropriate option you wish to print.

Payments Quick-Reference – Posting Payments

(for detailed information about Posting Payments see page 231)

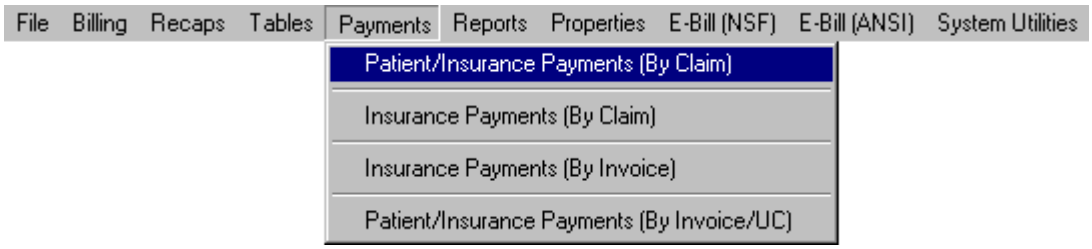
Payments can be posted in two ways in Quick-MD. You can post payments directly to charges in the patient's Ledger or you can use the Payment Posting Modules.

Ledger

To post a payment in the ledger, open the ledger and select the charge that you wish to apply the payment to. Hit the <F1> key to post a payment.

Posting Modules

Payments can also be posted through any of the four Patient Posting Modules in Quick-MD. Each is described briefly below:



Patient/Insurance Payments (By Claim) – Use the feature to post either Patient or Insurance Payments by Claim. Used to post Payments to ONE patient at a time. Allows you to quickly apply Un-applied credits to a patients claims.

Insurance Payments (By Claim) – Use the feature to post either Patient or Insurance Payments by Claim. Used to post Payments to more than one patient at a time.

Insurance Payments (By Invoice) – Use the feature to post either Patient or Insurance Payments by Invoice. Used to post Payments to more than one patient at a time.

Patient/Insurance Payments (By Invoice/UC) - Use the feature to post either Patient or Insurance Payments by Invoice. Used to post Payments to more than one patient at a time. If you are posting large EOB's, this is the module you want to use. This module also allows you to apply Un-applied credits to patient's claims.

IMPLEMENTING QUICK-MD FOR THE FIRST TIME

There are three different and distinct ways to implement a new Practice Management System.

1. The recommended way to convert from your existing system to Quick-MD, is to simply install Quick-MD on your network and **run parallel**. Meaning on a specified day, all patients from that point forward are entered as they come in and billed out of the new system. All patients prior to that specified date are billed out of the old system. As payments are received they are posted against the charge in the system they were billed out of. In a short time, the old system will wind down, usually 90 to 120 days. This also gives the office the opportunity to be sure all of the patient information is correct. By far the least expensive and less stressful way of implementing a new practice management system!

2. In some situations, a **data or partial data conversion** might be possible. This will all depend on whether or not the information out of the old system is available in an ASCII format. There are three things to keep in mind when considering a data conversion. A.) If there is trash data in your old system, there will trash in your new one also, as all of the bad comes over with the good during a conversion. B.) Never expect to be able to convert ledger history-only balance forwards. Therefore the old system has to stay up to be able to access history on claims that need refilling. C.) It is an additional expense to the office.

3. The third way is to do a **manual balance forward** set-up. This would also require the old system to stay up so the old claims would be accessible.

Below is an outline of the recommended steps for implementing Quick-MD.

1. Install **Quick-MD**
   *(for more information see **INSTALLING QUICK-MD** on page 37)*
2. Go to **System Utilities/Set Operator rights**-set up all users of the system, issue ID#'s and Passwords and define their degrees of operator rights.
   *(for more information see **USER RIGHTS** on page 286)*
3. Go to **Properties** and start with **Office Data**, then work your way down the menu populating all of the tables and fields that are applicable. In **Miscellaneous Defaults** there are many features that may be turned on and off to tweak the system to your way of doing business.
   *(for more information see **CUSTOMIZING QUICK-MD** on page 63)*
4. Go to **Tables** on the main screen of **Quick-MD**, and enter your Cpt codes, Diagnosis Codes, Insurance companies, and Referring Physicians.
   (for more information see Configuring Quick-MD on page 38)

You are now ready to start entering Patients and their charges!

If you have decided to use the **manual balance forward approach**, you will need to:

Gather information on all patients that have an account balance.

- Create a patient file for each of those patients, leaving the balances off at this point.

For each patient file:

- Fill in the general information
- Set up the patient's payment responsible parties (Primary Ins., Secondary Ins., Third Ins., and Patient/Other)
- Insert any standing diagnoses into the patient's diagnosis table. During the process of creating the patient files, you will need to set up a file for any new patients that come in and continue to use your old system in parallel with the new system.

After all patient files with a balance are set up, set up two new codes in your CPT code file, a BALANCE FORWARD INSURANCE and BALANCE FORWARD PATIENT code. The balance forward insurance code MUST HAVE an in-house code and CPT number of "BFI", the balance forward patient code MUST HAVE an in house code and CPT number of "BFP".

After your two balance forward CPT codes are set up in the master CPT code table, start entering the balances for each patient into Quick-MD. The portion of the balance that is insurance will be entered as a charge with the in-house CPT code of "BFI". The portion of the balance that is patient will be entered as a charge with the in-house code of "BFP". If a patient has an insurance and a patient balance, DO NOT enter the BFI and BFP codes on the same claim. Enter the BFI portion and *save* the charge, then enter the BFP portion and *save* the charge. In other words the BFI portion will be claim number one and the BFP portion will be claim number two.

***IMPORTANT:** Both balance forward entries must be on a claim of their own with no other charges on the claim.*

When you are at this phase of implementation it is important that you get the balances in as quickly as possible because at this time you will also need to enter all charges, payments, etc. into Quick-MD that the practice incurs. In other words, once the patient's balance forward is entered into Quick-MD then ALL charges, payments, adjustments and billings must be done in Quick-MD to keep the patient balance and billing statuses accurate. Payments, adjustments, etc. that apply to the balance forward charges are posted to the balance forward claims.

When all patients and their balances forwards are in Quick-MD you will then have Quick-MD produce an aging report by patient and compare Quick-MD balances with your information from outside Quick-MD to make sure all your transfers are accurate. Correct any mistakes you may find and the startup is complete. Run your pre-existing system parallel with the new system until you are comfortable with dropping the old system. When payments are received for charges that were brought across as balance forwards, post them to the charges in the old system as well to the balance forward in the new system. In a short amount of time the old system will wind down. Remember that you will still have to refer to your old system for detail and information on charges, payments, etc. that happened before the implementation of the new system.

Installing Quick-MD

Installing Quick-MD on the Server

1. Create a folder named "**qmed**" and share it out on the network.
2. Copy the contents of your installation CD into this folder via the DOS prompt.
3. Create a subdirectory under this folder and name it "**meddocs**"

Installing Quick-MD on the Clients

Create a new Short Cut that points to **quickmd.exe** in the shared **qmed** folder on the server.

Installing Q-Schedule on the Clients

Create a new Short Cut that points to **newaps.exe** in the shared **qmed** folder on the server.

Installing Multi-View Scheduler on The Clients

Create a new Short Cut that points to **book.exe** in the shared **qmed** folder on the server.

> ***Note**: You can only use the **Q-Schedule** or the **Multi-View Scheduler**, not both, so you will need to decide which one fits your needs. Once you have decide on the one that you want, make sure that all of the client's short cuts point to the correct executable.*

Setting up Mobile X-Ray

1. Set up the Business in the provider table.
    a. Go to the **Properties** Menu.
    b. Then, the **Provider Table**.
    c. Choose the provider button on the far right. *This should be provider number 26.*
    d. Enter the **Medicaid** and **Medicare** numbers.
2. Check the Mobile Xray box.
    a. Go to the **Properties** menu.
    b. Then, "**Miscellaneous Default Settings**"
    c. Next, "**Other Defaults**"
    d. Finally, check the "**File Claims For Mobile Xray**." Box.
3. Set the Medicare number in the Referring Physician / Facility table in the **Medicare upin#** field.
4. Set the Medicaid number in the Referring Physician / Facility table in the **Medicaid#** field.

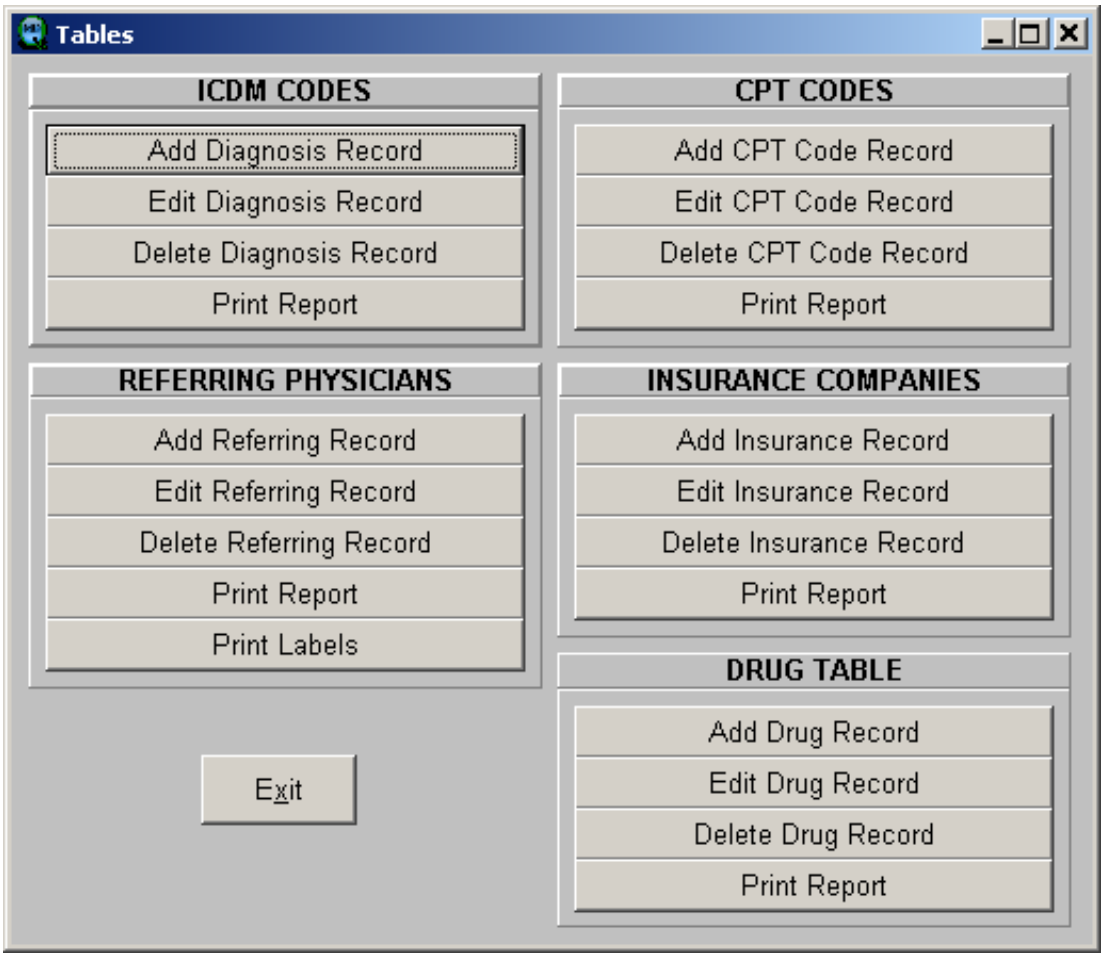
CONFIGURING QUICK-MD - THE TABLES MENU

Use this feature to populate and maintain the four main tables utilized by Quick-MD - **ICDM CODES**, **CPT CODES**, **REFERRING PHYSICIANS** and **INSURANCE RECORDS**.

> ***Note**: When configuring Quick-MD for the first time, you will want to populate the properties first, before moving on to the tables. In particular, you need to have you "Place Of Service" and "Type Of Service" codes set before you can enter your CPT codes.*

Getting there:

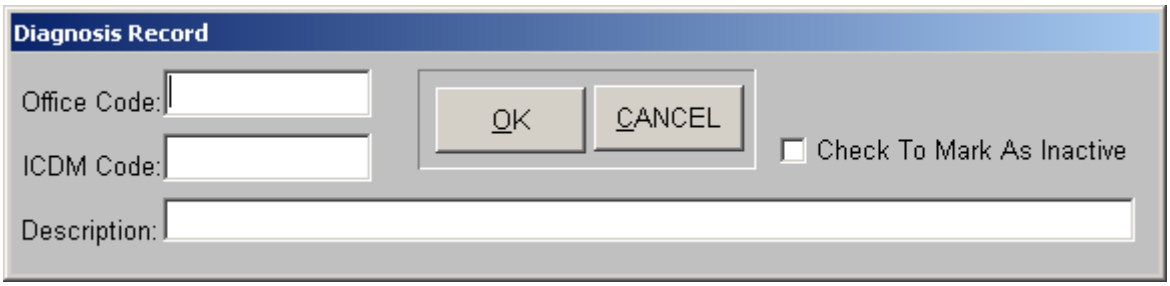
At "**QUICK-MD'S MAIN MENU**:" Select **TABLES**



ICDM (Diagnosis) CODES

This table maintains all of the Diagnosis Codes that your practice deals with. Use this feature to add, edit and delete your Diagnosis Codes.

Add Diagnosis Record



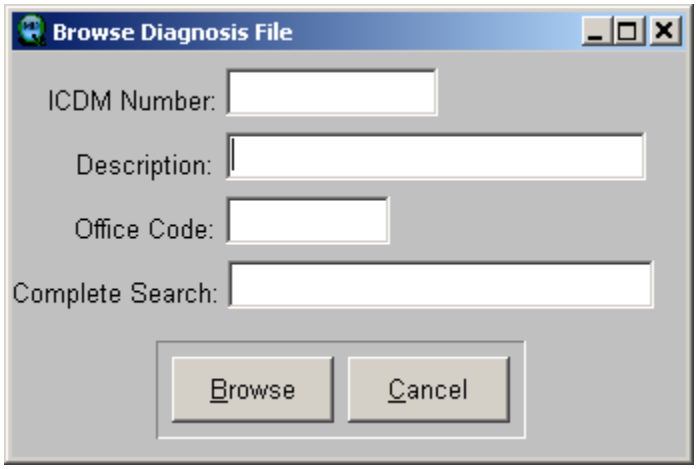
Office Code – Enter an Office code for the new record. In most instances you would use the same code as the ICDM Code you are setting up. But you can make this any code you wish. This allows the practice to refer to diagnoses records by any code they wish.

ICDM Code – Enter an ICDM code for the new record.

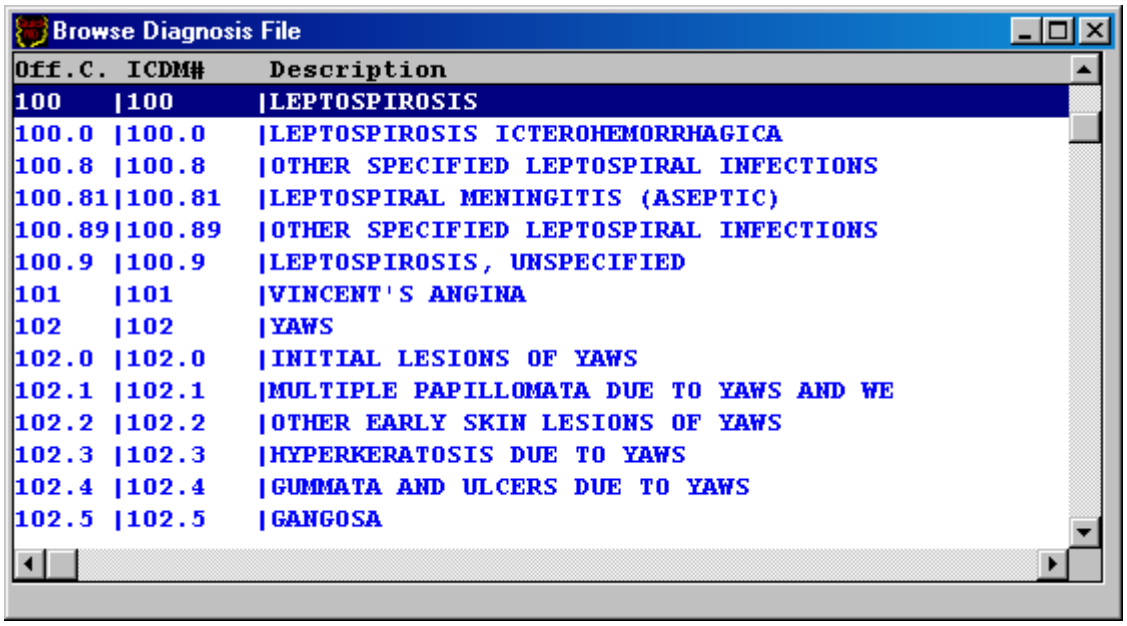
Description – Enter a description for the new record.

Edit Diagnosis Record

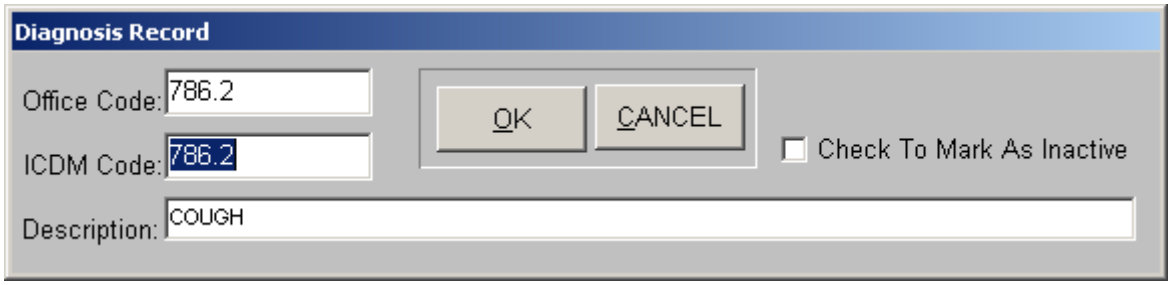
Use this feature to edit an existing ICDM code.



Enter one of the four pieces of information above and click **<Browse>**.

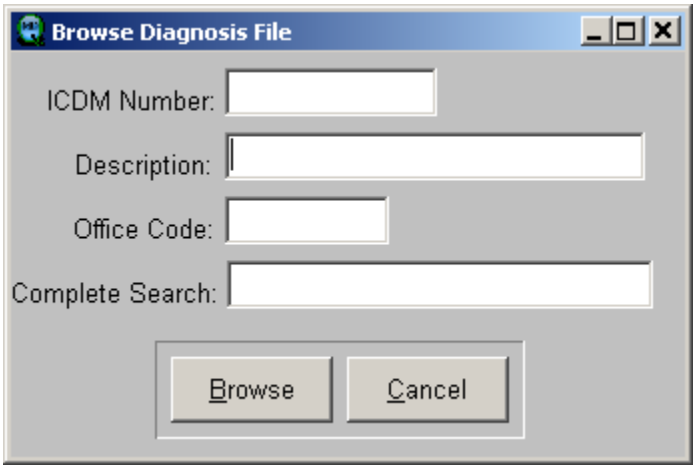

Browse Diagnosis File
Off.C. ICDM# Description
100 |100 |LEPTOSPIROSIS
100.0 |100.0 |LEPTOSPIROSIS ICTEROHEMORRHAGICA
100.8 |100.8 |OTHER SPECIFIED LEPTOSPIRAL INFECTIONS
100.81|100.81 |LEPTOSPIRAL MENINGITIS (ASEPTIC)
100.89|100.89 |OTHER SPECIFIED LEPTOSPIRAL INFECTIONS
100.9 |100.9 |LEPTOSPIROSIS, UNSPECIFIED
101 |101 |VINCENT'S ANGINA
102 |102 |YAWS
102.0 |102.0 |INITIAL LESIONS OF YAWS
102.1 |102.1 |MULTIPLE PAPILLOMATA DUE TO YAWS AND WE
102.2 |102.2 |OTHER EARLY SKIN LESIONS OF YAWS
102.3 |102.3 |HYPERKERATOSIS DUE TO YAWS
102.4 |102.4 |GUMMATA AND ULCERS DUE TO YAWS
102.5 |102.5 |GANGOSA

Select appropriate diagnosis record and hit **<ENTER>** or double click on record.

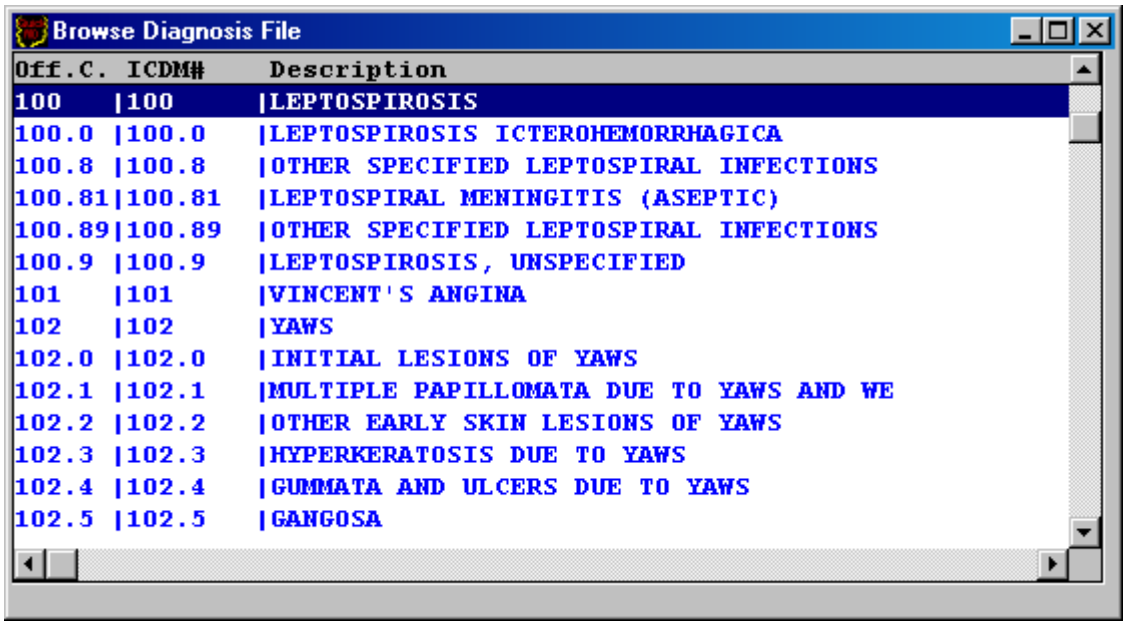


Make corrections to record and **<OK>**.

Deleting Diagnosis Record

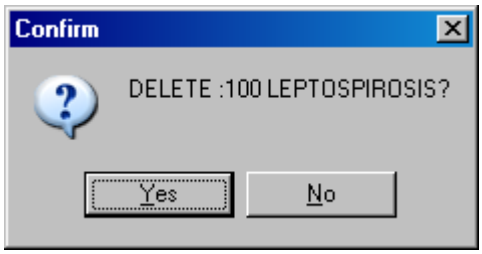


Enter one of the four pieces of information above and click **<BROWSE>**.


Browse Diagnosis File
Off.C. ICDM# Description
100 |100 |LEPTOSPIROSIS
100.0 |100.0 |LEPTOSPIROSIS ICTEROHEMORRHAGICA
100.8 |100.8 |OTHER SPECIFIED LEPTOSPIRAL INFECTIONS
100.81|100.81 |LEPTOSPIRAL MENINGITIS (ASEPTIC)
100.89|100.89 |OTHER SPECIFIED LEPTOSPIRAL INFECTIONS
100.9 |100.9 |LEPTOSPIROSIS, UNSPECIFIED
101 |101 |VINCENT'S ANGINA
102 |102 |YAWS
102.0 |102.0 |INITIAL LESIONS OF YAWS
102.1 |102.1 |MULTIPLE PAPILLOMATA DUE TO YAWS AND WE
102.2 |102.2 |OTHER EARLY SKIN LESIONS OF YAWS
102.3 |102.3 |HYPERKERATOSIS DUE TO YAWS
102.4 |102.4 |GUMMATA AND ULCERS DUE TO YAWS
102.5 |102.5 |GANGOSA

Choose a diagnosis record and hit **<ENTER>** or double click on the record.

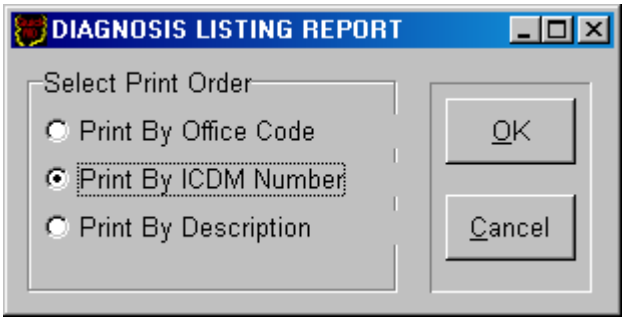
> ***WARNING:*** *Do not delete a record if it has been used in a patient file. This delete function is primarily used during the initial setup of the tables.*



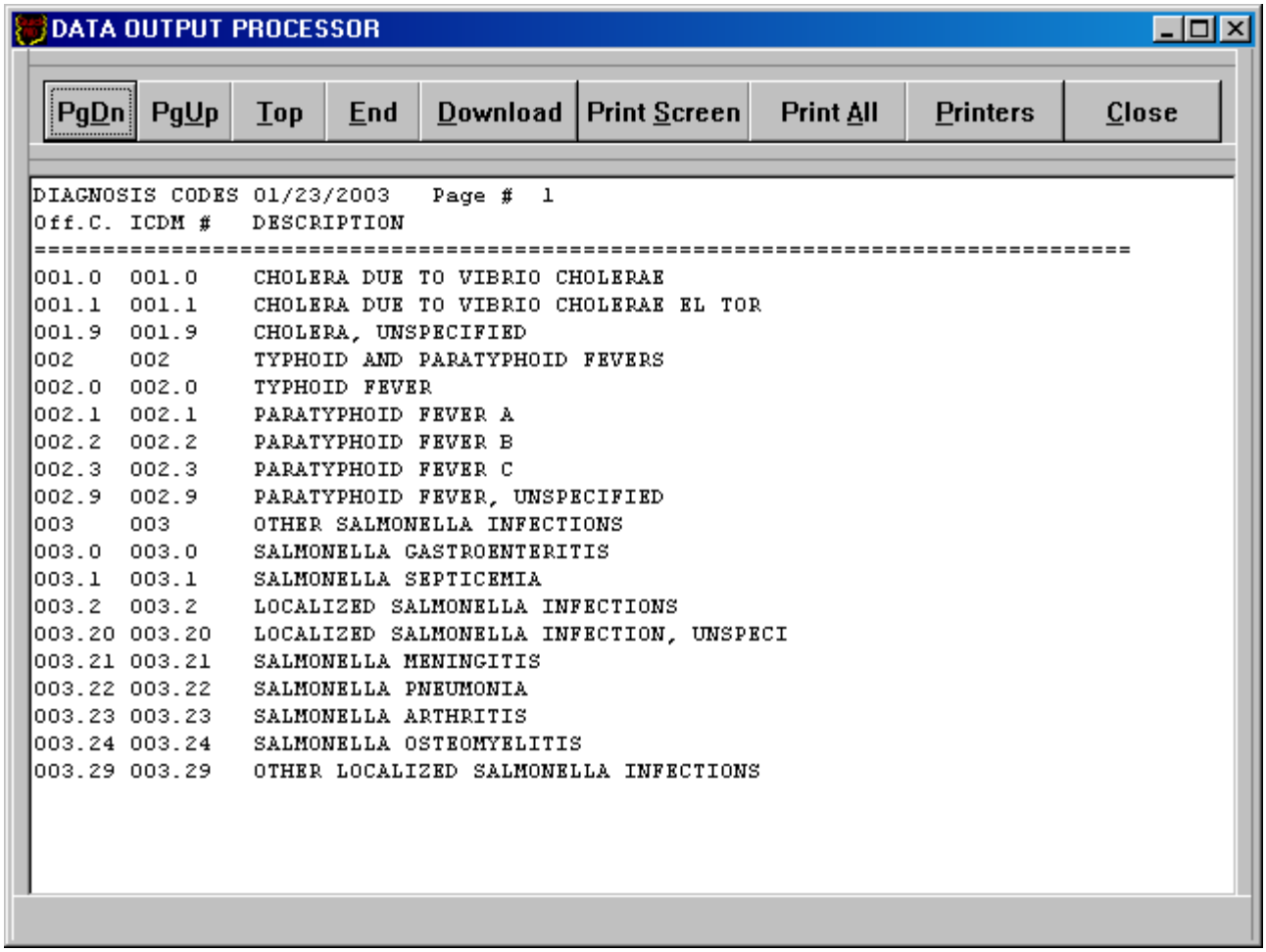
This screen confirms deletion of record. If you are sure you want to delete this record, choose **<YES>**. Otherwise, choose **<NO>**.

> ***NOTE:*** *Once deleted, a record cannot be recovered. The diagnosis would have to be added through the ADD function.*

Print Report



Select Print Order and then click **<OK>**.

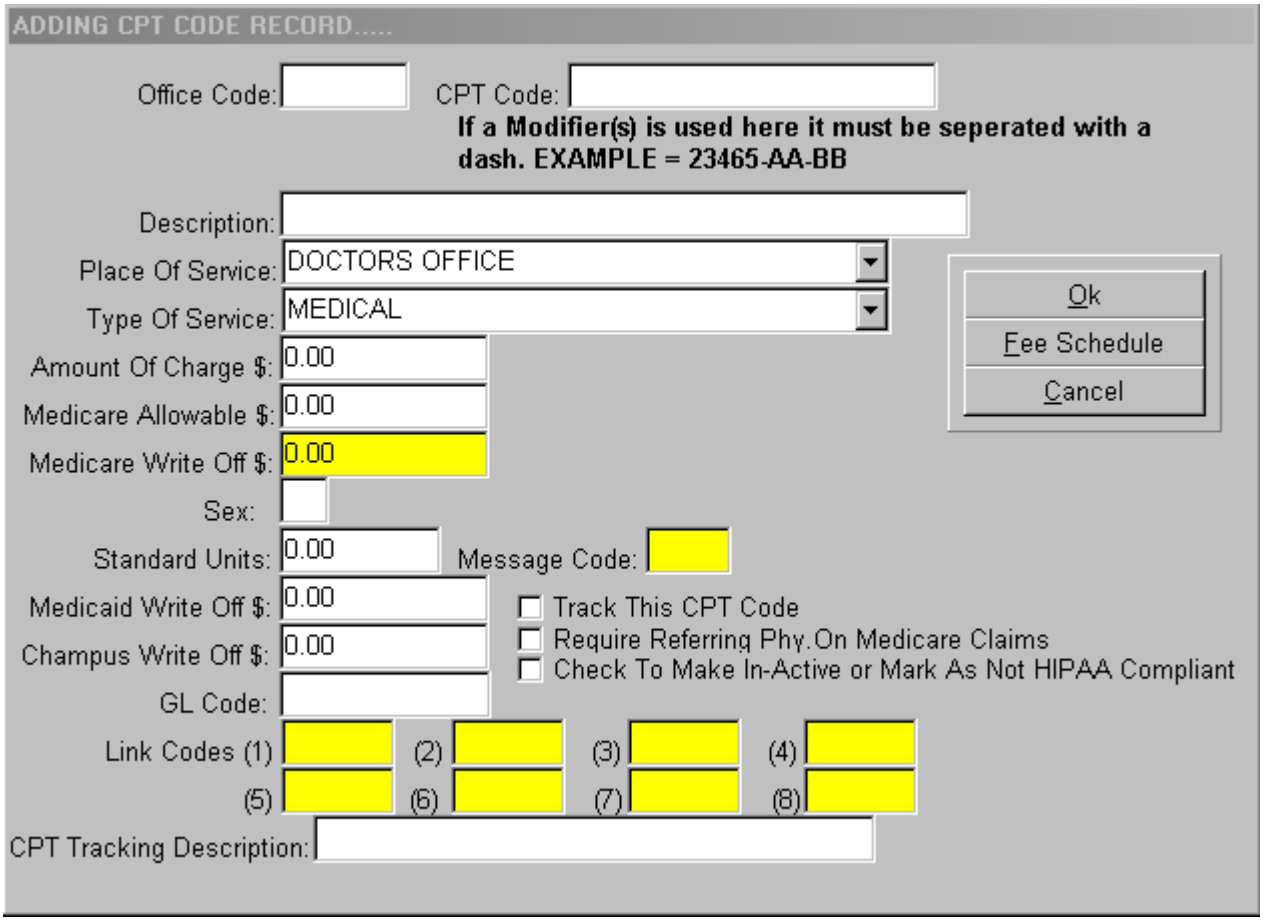


From the **DATA OUTPUT PROCESSOR**, you can either download or print the report.

CPT CODES

This table maintains all of the CPT Codes that your practice deals with. Use this feature to add, edit and delete your CPT Codes.

Adding CPT Code Record



Office Code – Enter your internal office code for this new CPT record. In most instances you would use the same code as the CPT code you are creating. But for added flexibility, Quick-MD allows you to enter your own internal code here. This gives you the ability to set the same CPT code up in various ways with different parameters (ie. different Place of Service, Type of Service and the Amount of Charges-with or without modifiers pre-attached. You may group CPTs by categories or bundle them together). This means that you can tailor CPT Codes to mirror the different scenarios that your practice engages in. Using Office Codes relieves the burden of having to modify these CPT codes at the time of charge entry, which reduces errors and boosts productivity.

CPT Code – Enter the CPT code for this new CPT record. You can attach up to three Modifiers to your CPT codes by simply adding them to the end of the CPT code. Note that there must be a dash between the cpt code and the modifier. For example 71020-TC. Quick-MD picks up the modifiers by recognizing the dash. Another example with two modifiers would be 12345-TC-AA and you can add up to three modifiers to your CPT record. 12345-TC-AA-XX

Description – Enter the description for this new CPT record.

Place Of Service – Choose the place of service where this new CPT record will be performed.

***NOTE:** The **PLACE OF SERVICE TABLE** (for more information see page 82) should include all places the provider performs services at.*

TYPE OF SERVICE – Choose the type of service that this new CPT record relates to.

***NOTE:** This **TYPE OF SERVICE** (for more information see page 83) should include all Types of services the providers offers.*

AMOUNT OF CHARGE – Enter your normal and customary charge for this new CPT record.

MEDICARE ALLOWABLE – Enter the amount Medicare will reimburse for this new CPT record.

MEDICARE WRITE OFF – Enter the difference between the amount of your charge and the total payments from Medicare and the patient for this CPT record.

MEDICAID WRITE OFF – Enter the difference between the amount of your charge and the total payments from Medicaid and the patient for this CPT record.

CHAMPUS WRITE OFF – Enter the difference between the amount of your charge and the total payments from Champus and the patient for this CPT record.

CHECK TO MAKE IN-ACTIVE – If checked, this will make the record inactive and you will be prompted that this record is inactive when generating charges. However, you are still allowed to use this record when generating charges.

SEX – Put appropriate sex if CPT is gender specific.

STANDARD UNITS – Enter number of units if the CPT record has a standard number of units associated with it.

GL CODE – This field allows for an external GL code to be entered for use in preparing financial statements.

REQUIRE REFERRING PHY ON MEDICARE CLAIMS – If checked, this will require that a referring physician is listed on all Medicare Claims.

MESSAGE CODE: – Hitting **<F1>** here allows you to attach a message from your canned notes to this CPT code. *(For more information on Canned Notes see page 289)* The attached messages will appear in the charge entry screen whenever this code is used. *(For more information see page 163)*

LINK CODES – this feature allows you to link this code to other CPT records. Use this feature when one CPT code is always used in conjunction with one or more other codes. Hitting **F1** allows you to browse your CPT records to pull the codes you wish to link into these fields.

TRACK THIS CPT CODE – Check this box to have Quick-MD track this code each time it is used on a patient's charge. You can easily access all the codes you've tracked from within the Patient's Demographic Screen. *(For more information see page 192)*

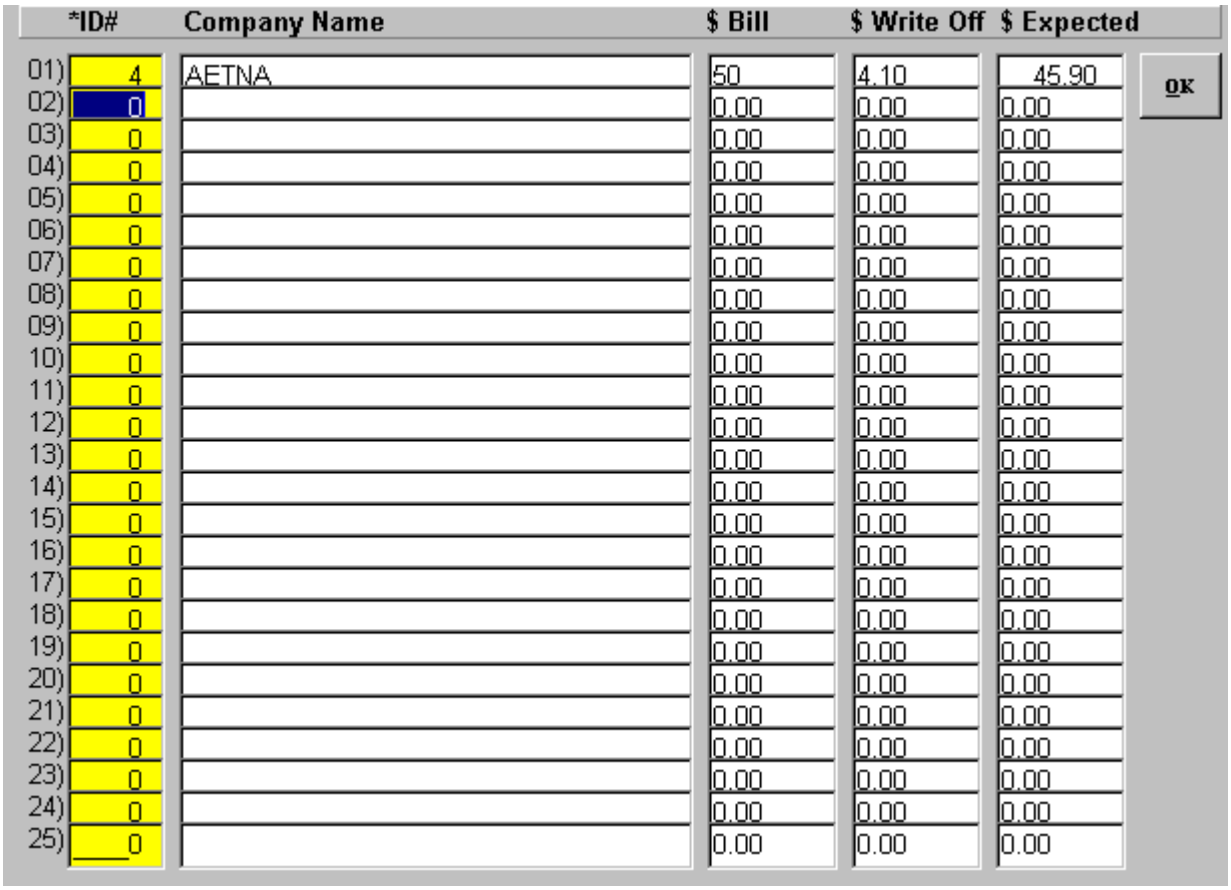
DESCRIPTION – Used only if you are tracking this CPT Code. This allows you to put your own description into the CPT tracking table. If you leave this blank, the normal CPT Code description will be used.

FEE SCHEDULE

This button allows you to link this CPT record with up to 25 fee schedules. These fee schedules can then be linked to insurance companies and it is possible to do automatic write-offs upon charge entry. If you want Quick-MD to automatically put the adjustment in the ledger at the same time of entering the charges, then turn the feature "**do automatic write-offs when entering charges**" on in **MISC. Defaults** as well as define to the system the **ID#'s for your adjustment codes.**
These are also listed at the top in **MISC Defaults**. *(for more information see page 91)*

To set up a fee schedule, pull in the id# of the insurance company, enter your normal and customary charge, subtract the negotiated fee from your normal charge, and enter that number into the write-off field. See note below.

> ***Note:*** *This is typically used when an insurance company reimburses on a schedule that is not related to the Medicare fee schedule. If the fee schedule is a percentage (%) of Medicare allowable, this fee schedule will be set in that insurance record. (Note: Medicare allowable has to be set in the CPT records for this to work.) It is also possible to tell the system to use a particular fee schedule that is already setup, in the insurance record, for that payer. See* ***Insurances in Main Tables***



ID# - Allows for the input of the insurance record that this fee schedule will be tied to. As always, this yellow field allows you to browse the Insurance Table by hitting **<F1>** and then pulling in the proper selection.

Company Name – this field will automatically be filled when the insurance company ID# is entered.

$ Bill – Enter the normal and customary charge amount for this CPT record.

$Write Off – Enter the difference between the normal and customary charge and the fee schedule-this is the write-off amount. It is possible to do automatic write-offs upon charge entry, if so desired. Turn the feature "**do automatic write-offs when entering charges**" on in **MISC. Defaults** as well as define to the system the **ID#'s for your adjustment codes.** These are also listed at the top in **MISC Defaults**.

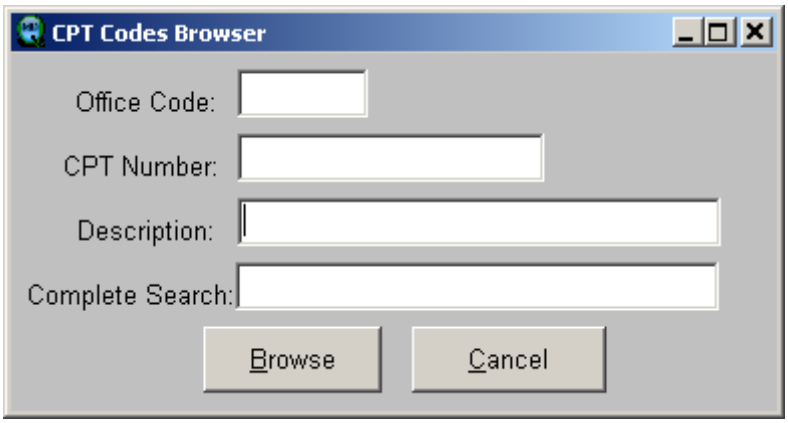
> ***Note:*** *This is typically used when an insurance company reimburses on a schedule that is not related to the Medicare fee schedule. If the fee schedule is tied to a percentage (%) of Medicare allowable, this fee schedule will be set in the insurance record (note: Medicare allowable will have to be set in each CPT record.). It is also possible to tell the system to use a particular fee schedule that is already setup, in the insurance record for that payer. See* ***Insurances in Main Tables***

$ EXPECTED – Enter your negotiated price that you are expecting the insurance company to reimburse you. Quick-MD will warn you at the time you are posting payments if the amount is different from your negotiated price.

> ***NOTE:*** *In order for this to work you must check "Compare Ins. Payments to Expected $ Amount" in* ***<Properties>*** *-* ***<Misc Defaults>*** *-* ***<Other Defaults>****. (For more information see page 98)*

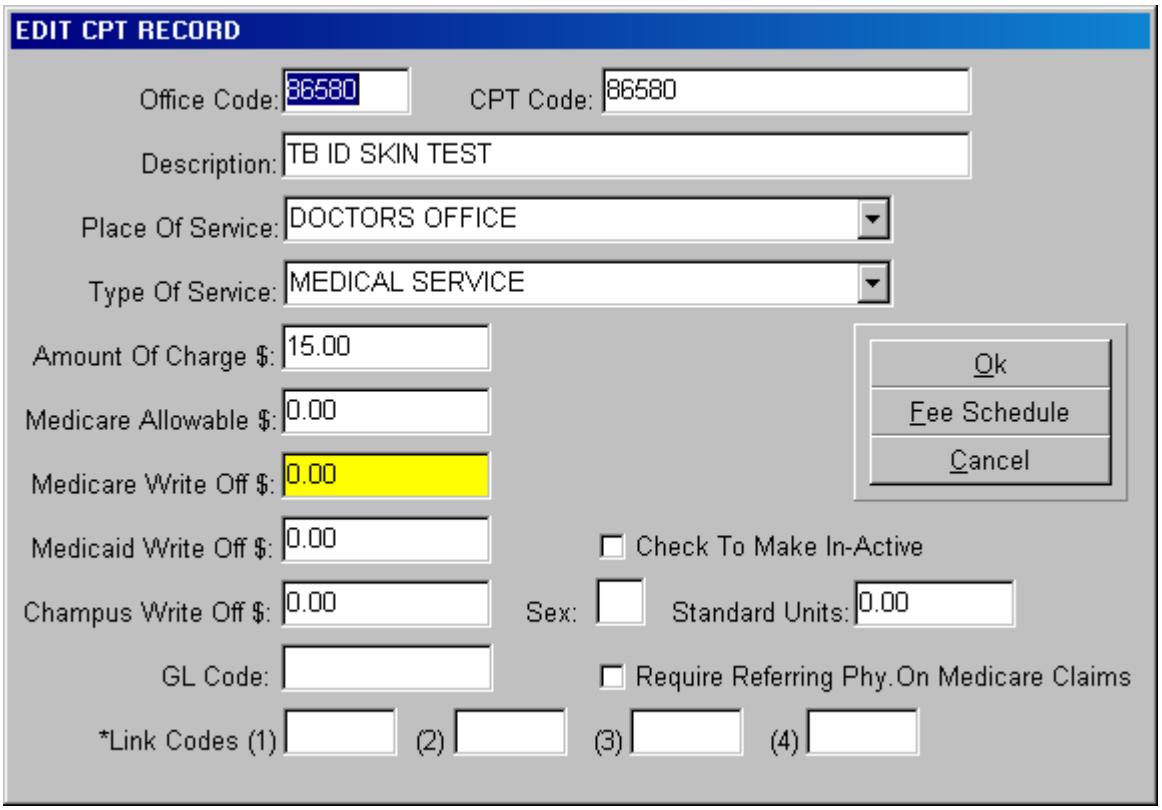
When done, click **<OK>** to save.

Edit CPT Code Record



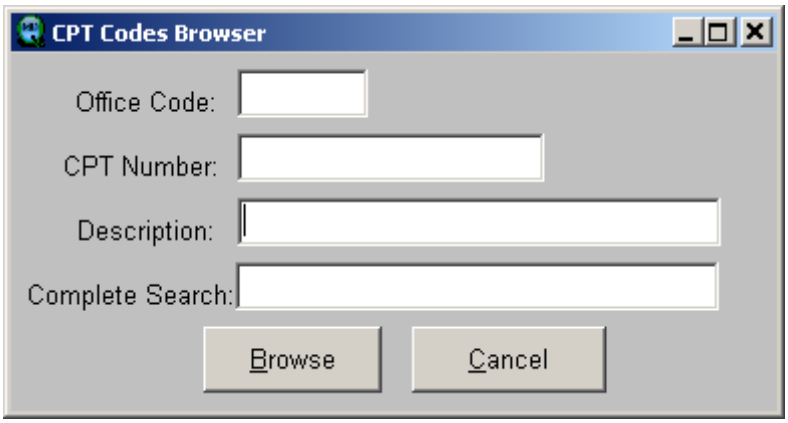
Enter one of the four pieces of information above and click **<BROWSE>**.

Choose CPT code record and hit **<ENTER>** or double click on a record.



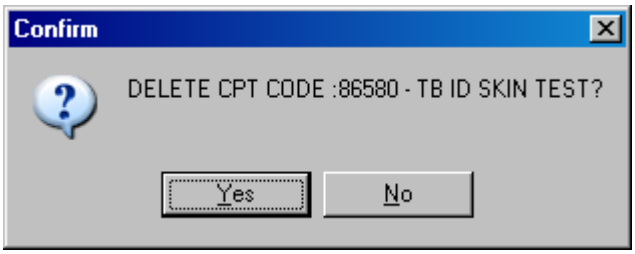
Make any corrections you wish and select **<OK>**.

Delete CPT Code Record



Enter one of the four pieces of information above and click **<BROWSE>**.

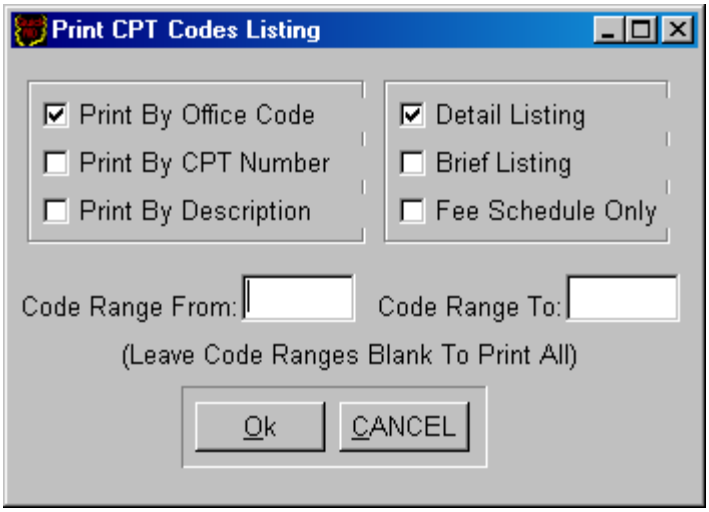
Choose a CPT code record and hit **<ENTER>** or double click on the record.



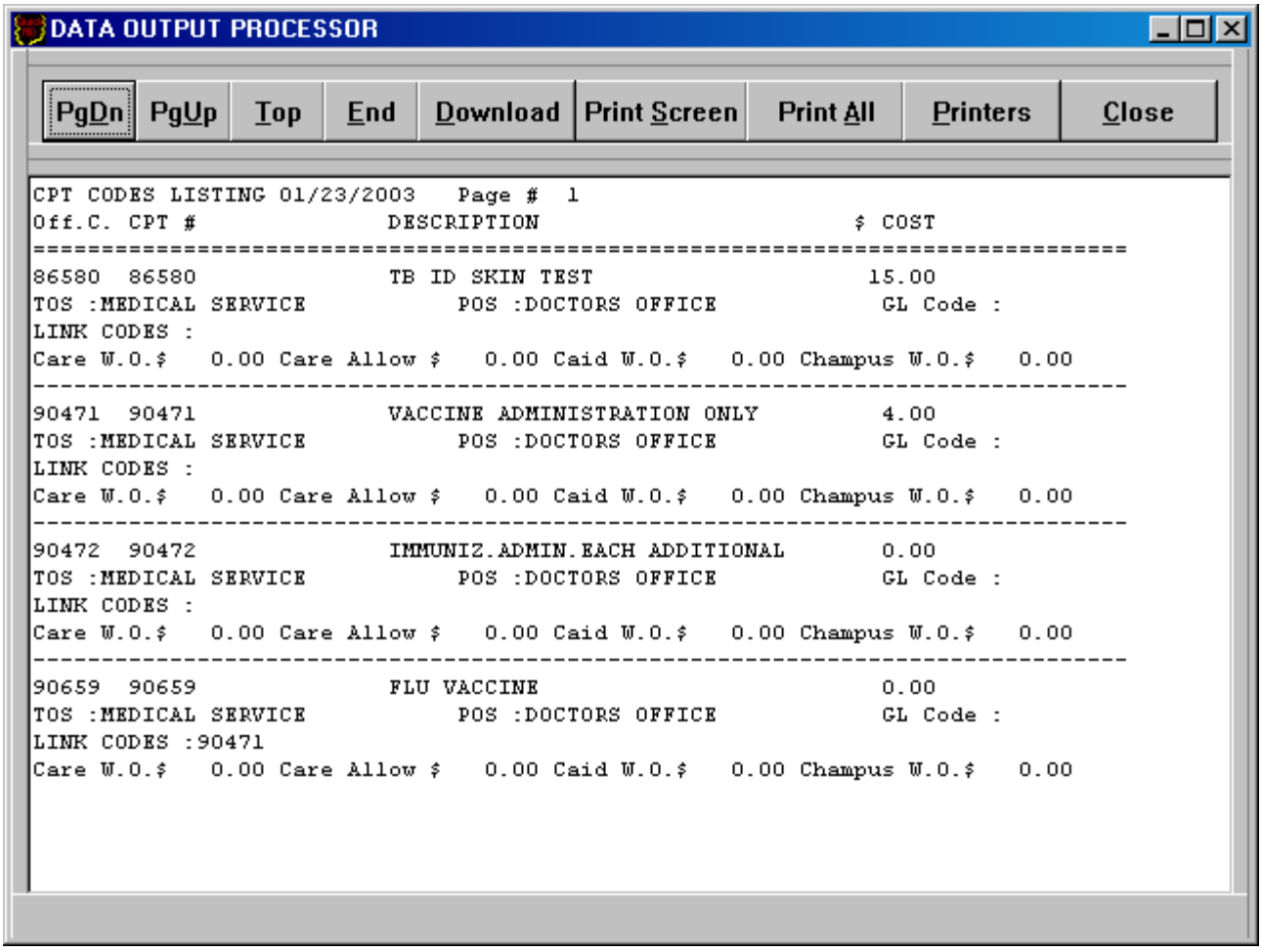
This screen confirms deletion of the record. If you are sure you want to delete this record, choose **<YES>**. Otherwise, choose **<NO>**.

> ***NOTE:*** *Once deleted, a record cannot be recovered. You would have to reenter the CPT code through the ADD function.*
>
> ***IMPORTANT:*** *DO NOT DELETE A RECORD IF IT HAS BEEN USED IN A PATIENT FILE. THE DELETE FUNCTION IS PRIMARILY USED DURING INITIAL SETUP OF THE TABLES.*

Print Report



Select Print Order, Report Enter, or range of codes, and **<OK>**.


DATA OUTPUT PROCESSOR
PgDn
PgUp
Top
End
Download
Print Screen
Print All
Printers
Close
CPT CODES LISTING 01/23/2003 Page # 1
Off.C. CPT # DESCRIPTION $ COST
86580 86580 TB ID SKIN TEST 15.00
TOS :MEDICAL SERVICE POS :DOCTORS OFFICE GL Code :
LINK CODES :
Care W.O.$ 0.00 Care Allow $ 0.00 Caid W.O.$ 0.00 Champus W.O.$ 0.00
90471 90471 VACCINE ADMINISTRATION ONLY 4.00
TOS :MEDICAL SERVICE POS :DOCTORS OFFICE GL Code :
LINK CODES :
Care W.O.$ 0.00 Care Allow $ 0.00 Caid W.O.$ 0.00 Champus W.O.$ 0.00
90472 90472 IMMUNIZ.ADMIN.EACH ADDITIONAL 0.00
TOS :MEDICAL SERVICE POS :DOCTORS OFFICE GL Code :
LINK CODES :
Care W.O.$ 0.00 Care Allow $ 0.00 Caid W.O.$ 0.00 Champus W.O.$ 0.00
90659 90659 FLU VACCINE 0.00
TOS :MEDICAL SERVICE POS :DOCTORS OFFICE GL Code :
LINK CODES :90471
Care W.O.$ 0.00 Care Allow $ 0.00 Caid W.O.$ 0.00 Champus W.O.$ 0.00

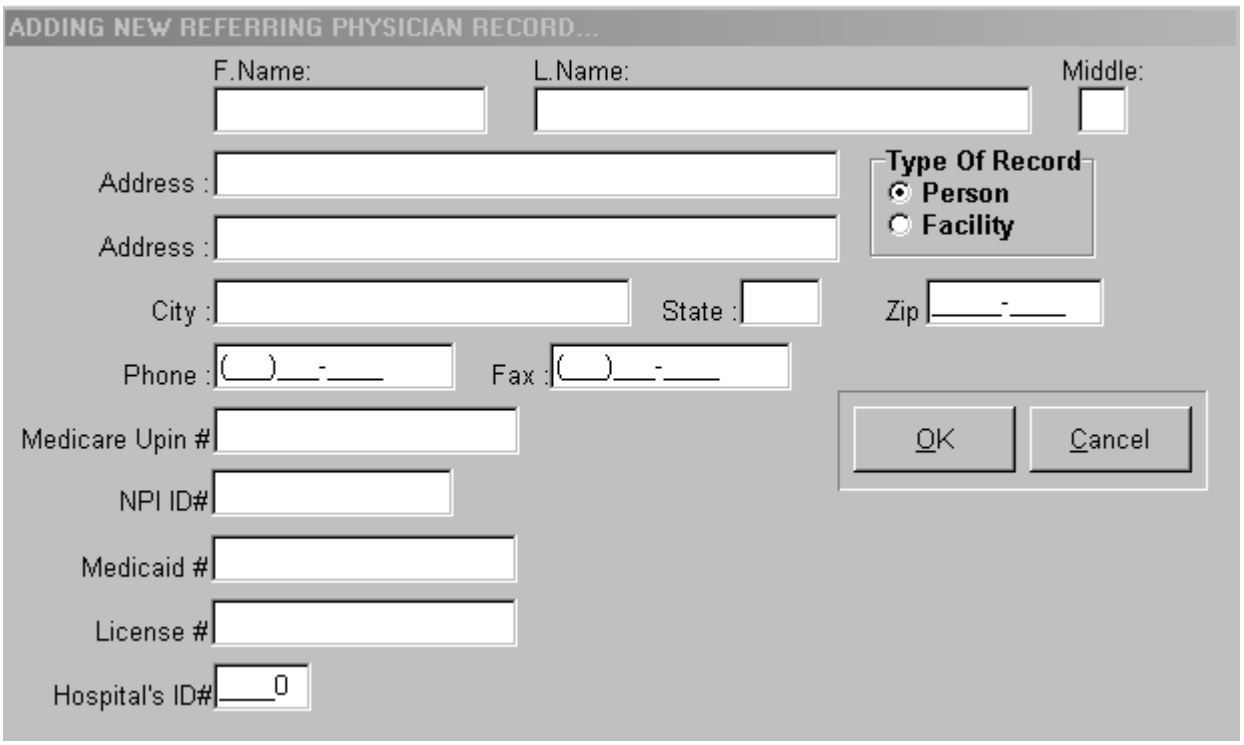
From the **DATA OUTPUT PROCESSOR**, you can either download or print the report.

REFERRING PHYSICIANS

This table maintains all of the referring physicians that your practice deals with. Use this feature to add, edit and delete your referring physician records.

***NOTE:** This table is used for both referring physicians, the facility where the service is rendered and pharmacies.*

Adding Referring Record



F. NAME – Enter physician's first name

L. NAME – Enter physician's last name

MIDDLE – Enter physician's middle initial

ADDRESS – Enter physician's address on both lines, if needed

CITY – Enter physician's city

***NOTE:** zip code records do not work in this area*

STATE – Enter physician's state

ZIP – Enter physician's zip code

PHONE – Enter physician's phone number

MEDICARE PIN# – Enter physician's Medicare Pin#

MEDICAID# – Enter physician's Medicaid #

LICENSE# – Enter license number if this record is for a FACILITY. If not a facility, leave blank.

Hospital ID# – This field is used only by labs importing data from a hospital and is not applicable for physicians.

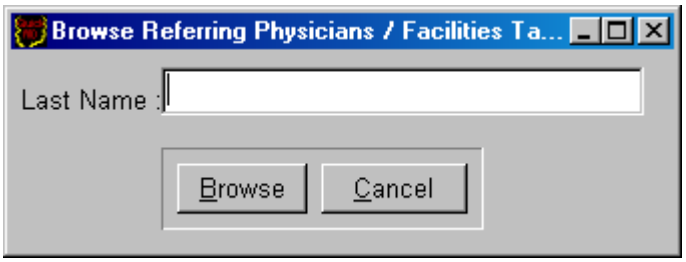
Type of Record – This field defines whether this record is a person or a facility. All new records are marked as a person by default. If this record is to be a facility, then check the facility box. When the record is a facility, you must enter the information in the last name field only. Do not put anything in the first name field!

<Ok> – saves the record.

<Cancel> – Exits without saving changes.

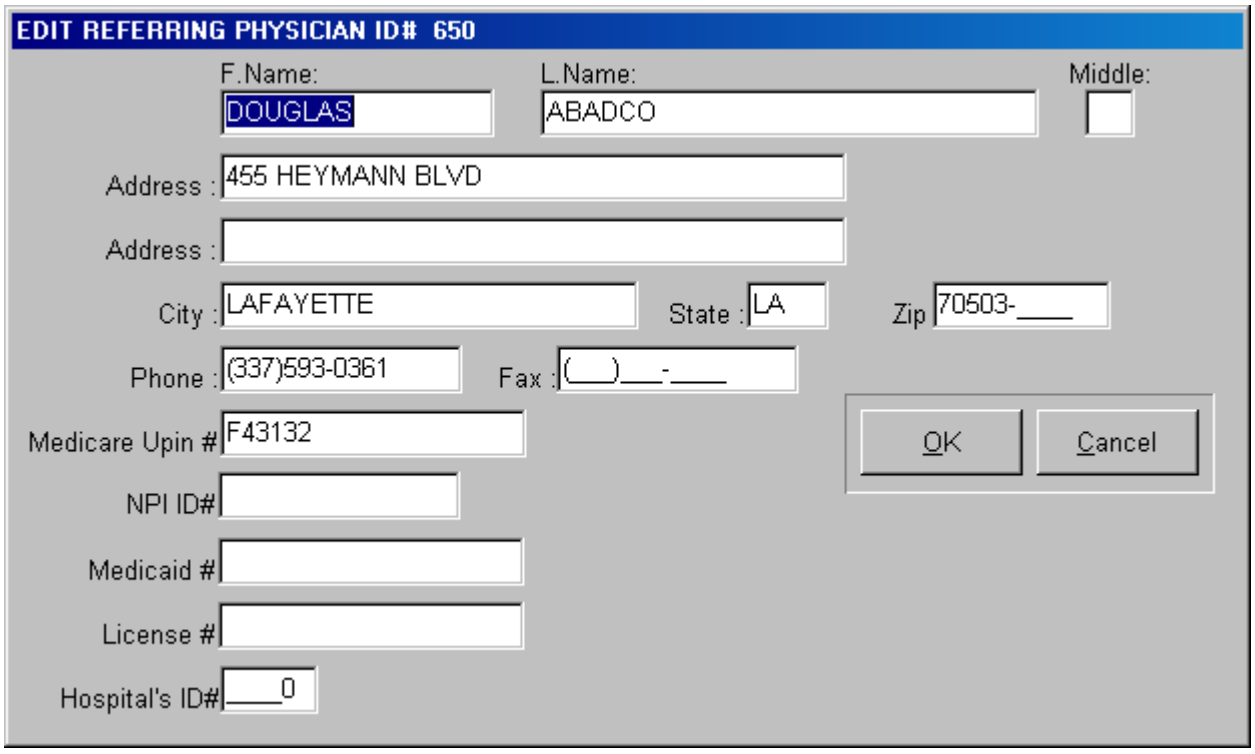
***Note:** When adding a referring facility record, facility name is entered in the L. Name field.*

Edit Referring Record



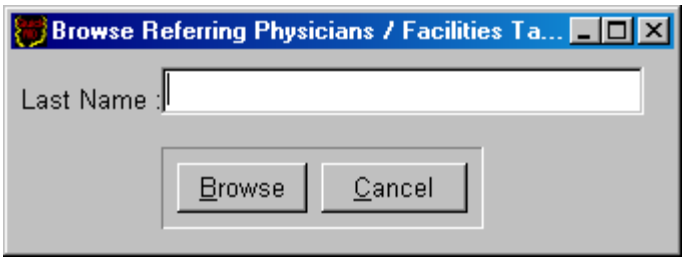
Enter last name and click **<Browse>.**

Choose record and hit **<Enter>** or double click on record.

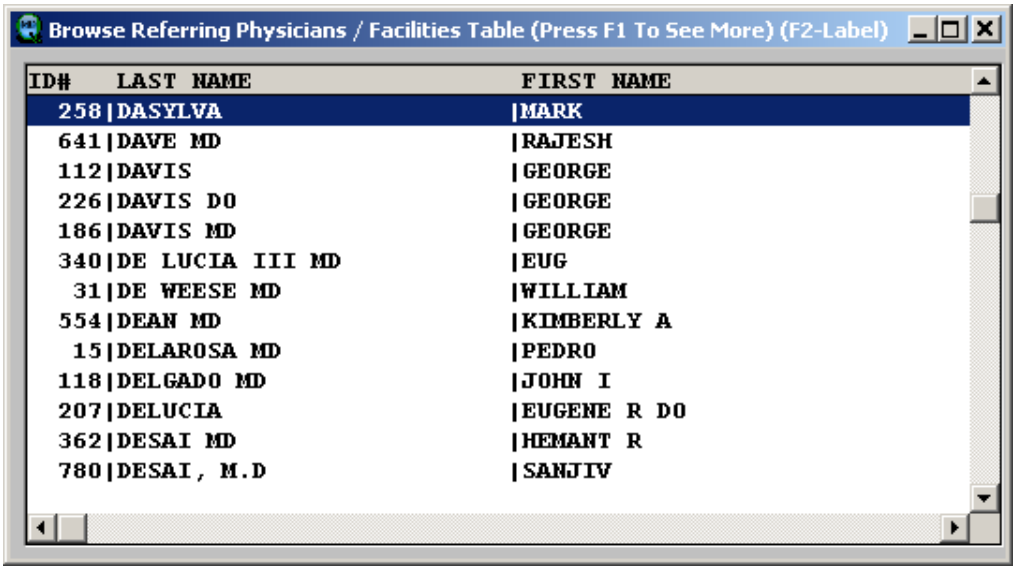


Make corrections to record and **<Ok>**.

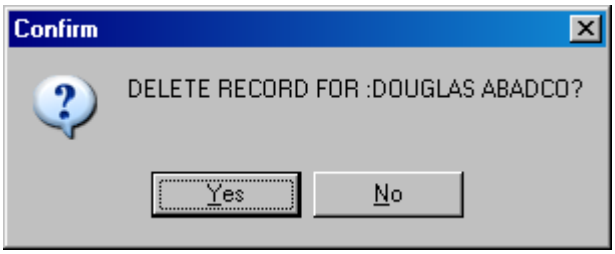
Delete Referring Record



Enter last name and **<BROWSE>**


Browse Referring Physicians / Facilities Table (Press F1 To See More) (F2-Label)
ID# LAST NAME FIRST NAME
258|DASYLVA |MARK
641|DAVE MD |RAJESH
112|DAVIS |GEORGE
226|DAVIS DO |GEORGE
186|DAVIS MD |GEORGE
340|DE LUCIA III MD |EUG
31|DE WEESE MD |WILLIAM
554|DEAN MD |KIMBERLY A
15|DELAROSA MD |PEDRO
118|DELGADO MD |JOHN I
207|DELUCIA |EUGENE R DO
362|DESAI MD |HEMANT R
780|DESAI, M.D |SANJIV

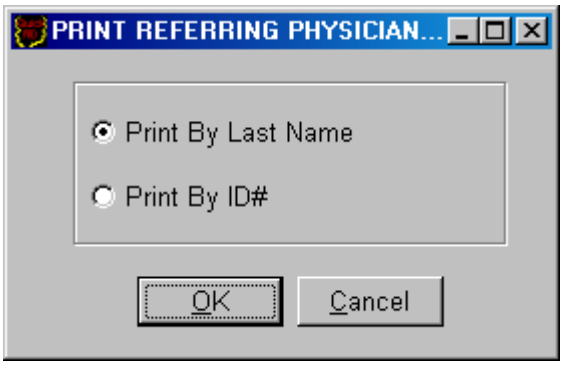
Choose record and hit **<ENTER>** or double click on record.



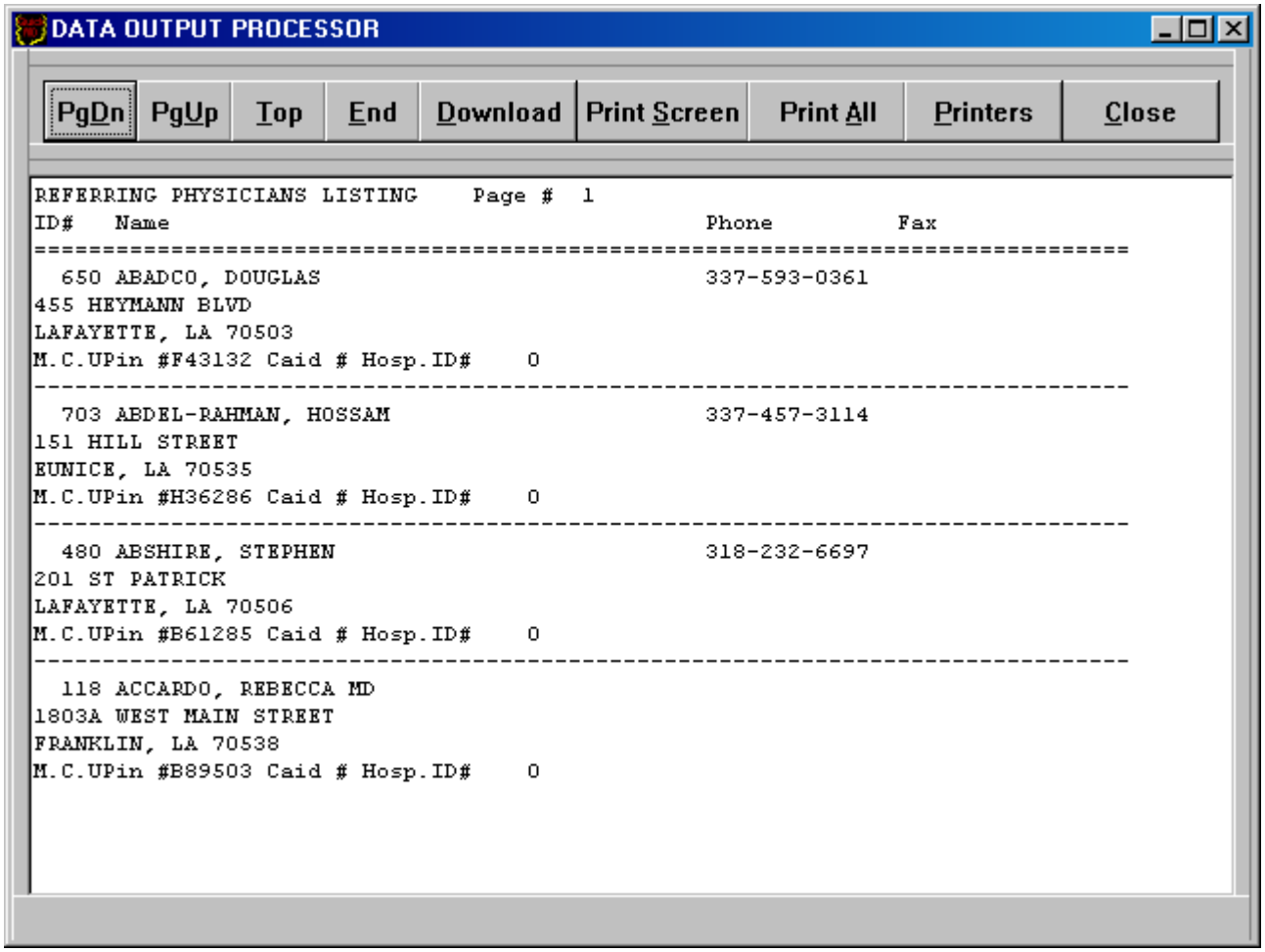
This screen confirms deletion of the record. If you are sure you want to delete this record, choose **<YES>**. Otherwise, choose **<NO>**.

> ***NOTE:*** *Once deleted, a record cannot be recovered. You would have to reenter the referring physician through the ADD function.*
>
> ***WARNING:*** *DO NOT DELETE A RECORD IF IT HAS EVER BEEN USED IN A PATIENT FILE. THE DELETE FUNCTION IS PRIMARILY USED DURING INITIAL SETUP OF THE TABLES.*

Print Report



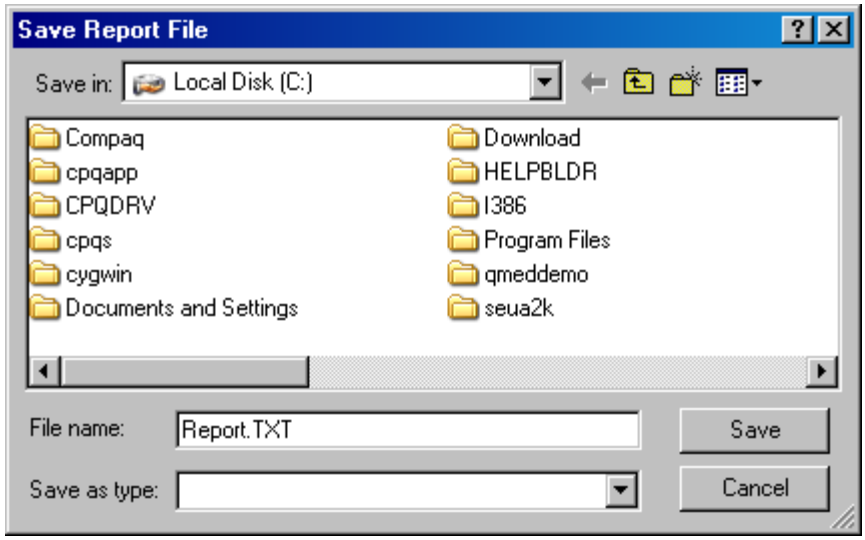
Select Print Order and **<OK>**.



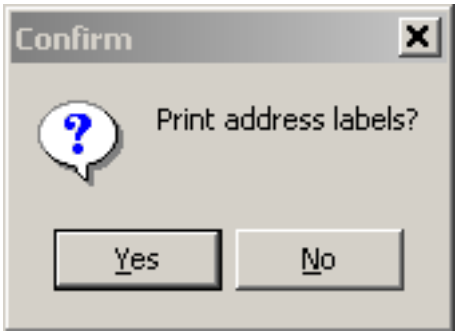
From the **Data Output Processor**, you can either download or print the report.

Downloading Reports to Text Files

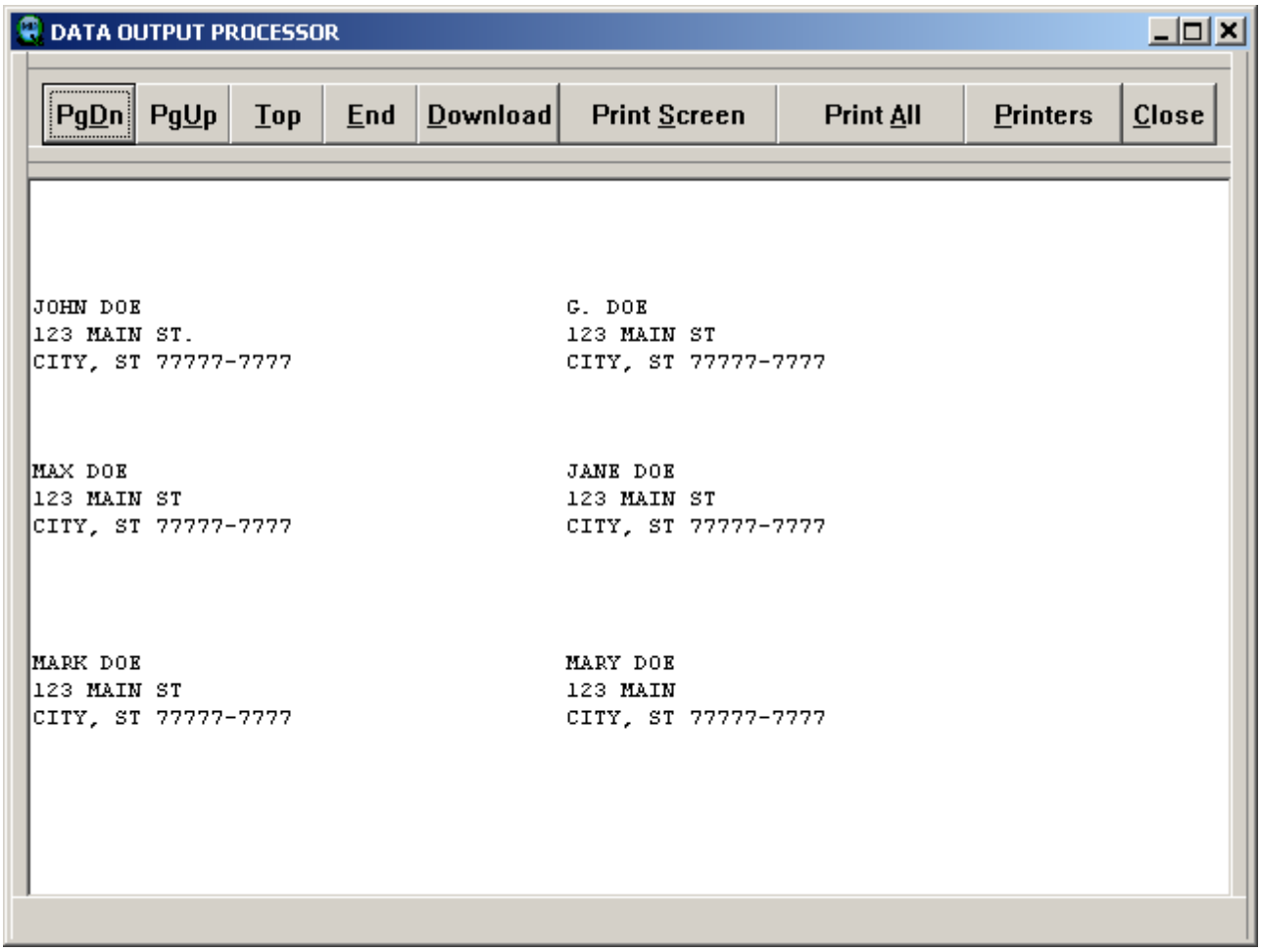
All reports can be saved to text files for use with an external program. Simply choose the folder where you want the file placed and then give it a name.


Save Report File
Save in:
Local Disk (C:)
Compaq
cpqapp
CPQDRV
cpqs
cygwin
Documents and Settings
Download
HELPBLDR
I386
Program Files
qmeddemo
seua2k
File name:
Report.TXT
Save
Save as type:
Cancel

PRINT LABELS



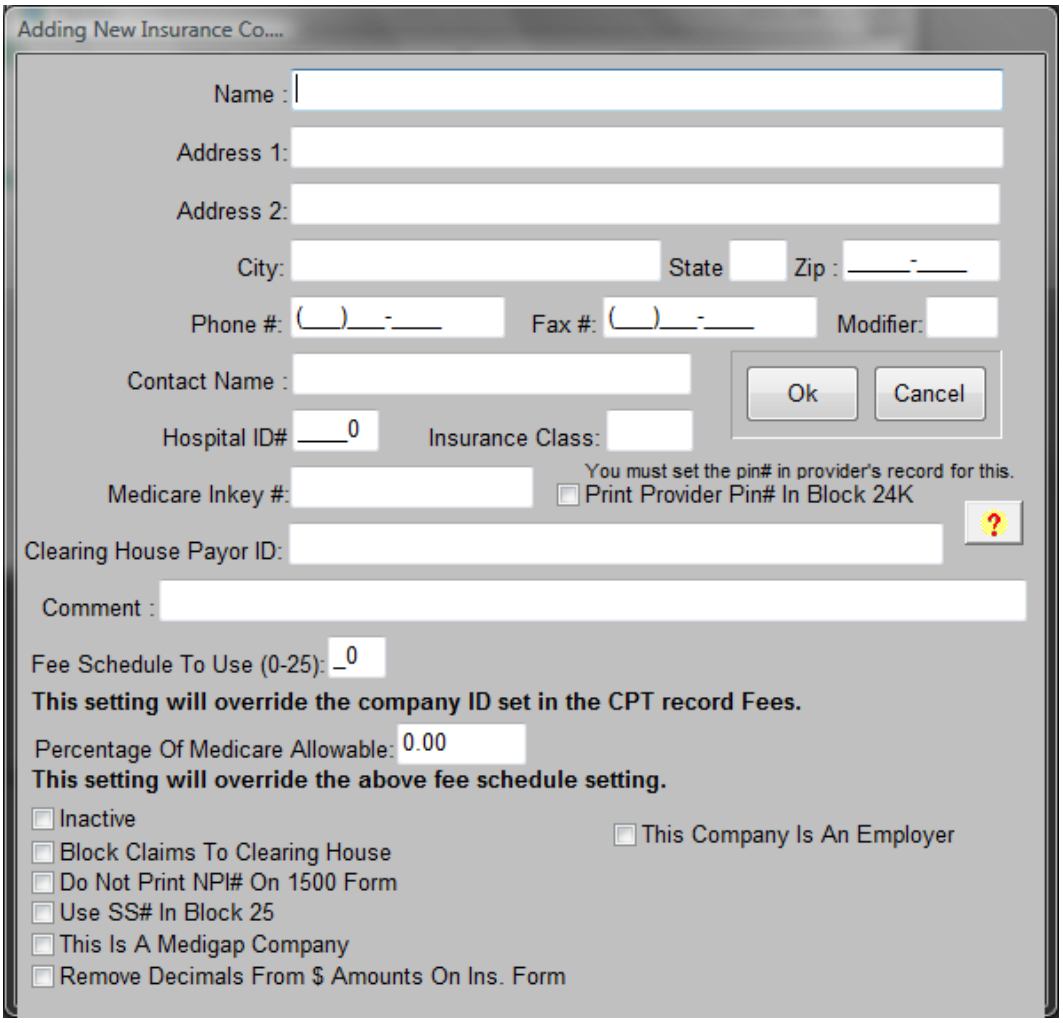
Choose yes here and you will get a list of mailing labels for all of the referring Physicians and facilities in your database.



INSURANCE COMPANIES

This table maintains all of the insurance companies that your practice deals with. Use this feature to add, edit and delete your insurance records.

Add Insurance Record



Name – Enter insurance company name

Address 1 – Enter insurance company address

Address 2 – Enter second line of insurance company address, if applicable

City – Enter insurance company's city.

Note: *Do not enter a zip code here. That feature is only used on the patient demographics screen.*

State – Enter insurance company's state

Zip – Enter insurance company's zip code

Phone – Enter insurance company's phone number

FAX – Enter insurance company's fax number

Modifier – Enter insurance company's modifier that will be attached to all charges submitted to this

company, if applicable.

Contact Name – Enter insurance company's contact person's name

Hospital ID# – This field is used only by labs importing data from a hospital and is not applicable for physicians.

Insurance Class#- This features is used to assign a single Provider Pin# to multiple insurance companies. This allows you to group insurance companies together by assigning them the same Class Code. Once these codes are assigned to the individual insurance records you can reference them from within the **Provider Table** *(for more information see page 65)* to define what Pin# they will be assigned.

Example: You might have 15 Blue Cross/Blue Shield insurance companies in your insurance tables and want to define the Providers Pin# to all of them. In this instance, you would give them a class of **BCBS** (or whatever you wish). Then in the Provider Table, you would assign this class whatever number is appropriate.

Print Provider PIN# in 24K – If checked, this will put the provider's pin number in block 24K. The PIN number is pulled from the provider table and must be set there for this to work. *(For more information see page 65)*

Inactive – If checked, this will make record inactive and you will be prompted that this record is inactive when accessing the table. However, you may still utilize this insurance record.

MCR Filing ID# – Enter the MCR electronic filing ID#, if this is a MCR supplemental, if applicable.

Clearing House Payer ID – Enter insurance company's clearinghouse payer ID, if applicable

Comment – Enter any miscellaneous comment regarding this particular insurance company.

Block Claims to Clearing House – If checked, no claims for this insurance company will be sent electronically to the clearing house. These claims will be generated on paper.

Fee Schedule to Use (0-25) – Enter the fee schedule table number assigned to this insurance company, if applicable. *(for more information see **Adding CPT Code Record** on page 43)*

Note: *Entering a fee schedule table number in this field will override the company ID set in the CPT record fee schedules.*

Percentage of Medicare Allowable – Enter in this field the percentage of the Medicare fee schedule that this insurance company will pay, if applicable. For example, 150% of the Medicare fee schedule would be entered as 150. The Medicare allowable has to be set in the CPT records for this to work.

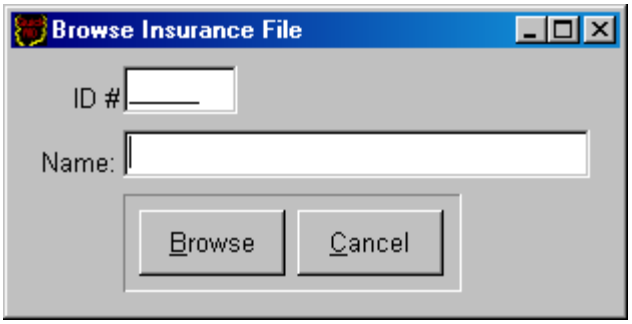
Note: *This setting will override the above fee schedule setting.*

remove decimals from $ amounts on ins form – Check this box, if for this insurance company, you need to have the decimal points removed from all of the amount fields that print on the 1500 form.

This company is an employer – Check this box if this company is used as an employer. Company that are set as employer will show up green in the insurance browser.

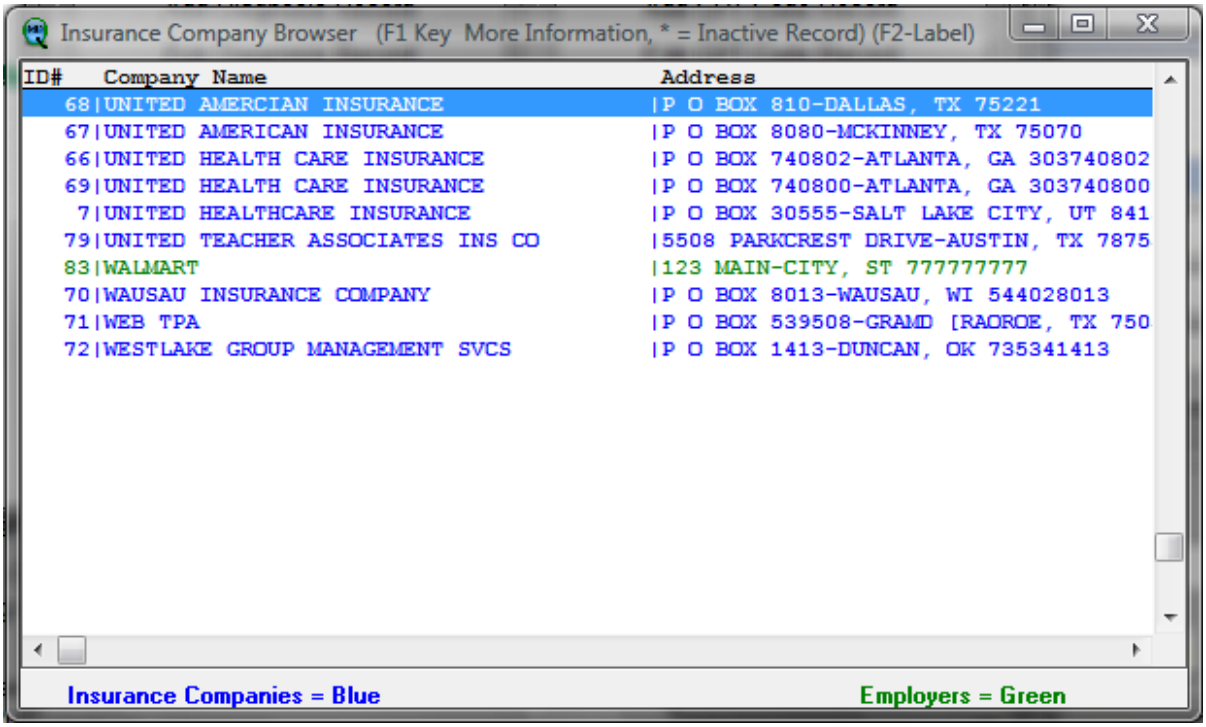
<Ok> – saves the record.

Edit Insurance Record



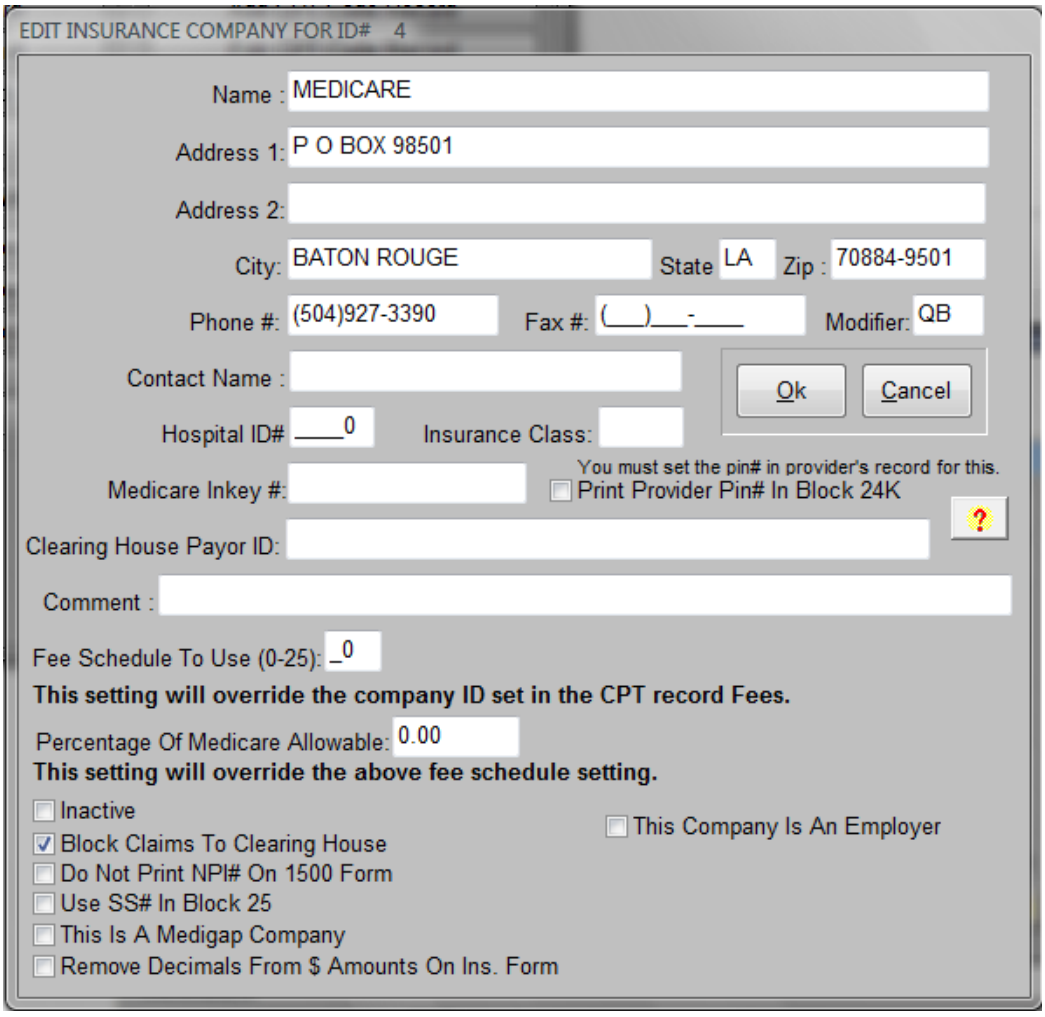
ID – Enter the Insurance ID if known. Use the **<F1>** key to browse the table if the ID is not known.

NAME – Enter Name or partial name of the insurance company.


Insurance Company Browser (F1 Key More Information, * = Inactive Record) (F2-Label)
ID# Company Name Address
68|UNITED AMERCIAN INSURANCE |P O BOX 810-DALLAS, TX 75221
67|UNITED AMERICAN INSURANCE |P O BOX 8080-MCKINNEY, TX 75070
66|UNITED HEALTH CARE INSURANCE |P O BOX 740802-ATLANTA, GA 303740802
69|UNITED HEALTH CARE INSURANCE |P O BOX 740800-ATLANTA, GA 303740800
7|UNITED HEALTHCARE INSURANCE |P O BOX 30555-SALT LAKE CITY, UT 841
79|UNITED TEACHER ASSOCIATES INS CO |5508 PARKCREST DRIVE-AUSTIN, TX 7875
83|WALMART |123 MAIN-CITY, ST 777777777
70|WAUSAU INSURANCE COMPANY |P O BOX 8013-WAUSAU, WI 544028013
71|WEB TPA |P O BOX 539508-GRAMD [RAORDE, TX 750
72|WESTLAKE GROUP MANAGEMENT SVCS |P O BOX 1413-DUNCAN, OK 735341413
Insurance Companies = Blue
Employers = Green

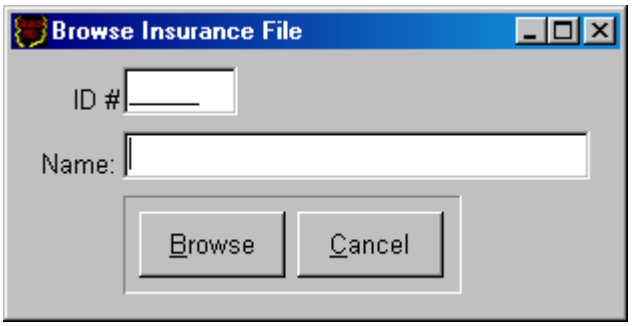
Select record and hit **<ENTER>** or double click on record.

NOTE: *Employers will be listed in green on the Browse screen.*

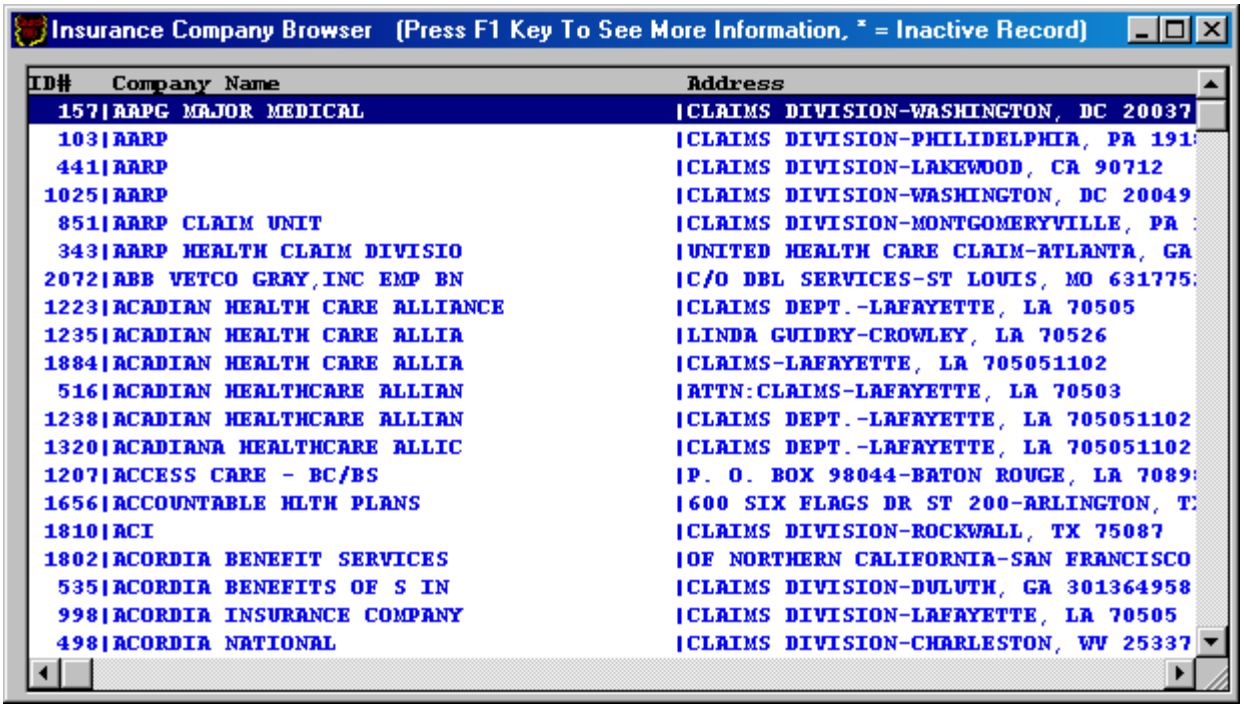

EDIT INSURANCE COMPANY FOR ID# 4
Name : MEDICARE
Address 1: P O BOX 98501
Address 2:
City: BATON ROUGE
State LA
Zip : 70884-9501
Phone #: (504)927-3390
Fax #: (___)___-____
Modifier: QB
Contact Name :
Ok
Cancel
Hospital ID# ____0
Insurance Class:
You must set the pin# in provider's record for this.
Medicare Inkey #:
Print Provider Pin# In Block 24K
Clearing House Payor ID:
Comment :
Fee Schedule To Use (0-25): _0
This setting will override the company ID set in the CPT record Fees.
Percentage Of Medicare Allowable: 0.00
This setting will override the above fee schedule setting.
Inactive
Block Claims To Clearing House
Do Not Print NPI# On 1500 Form
Use SS# In Block 25
This Is A Medigap Company
Remove Decimals From $ Amounts On Ins. Form
This Company Is An Employer

Make corrections to the record and click **<OK>**.

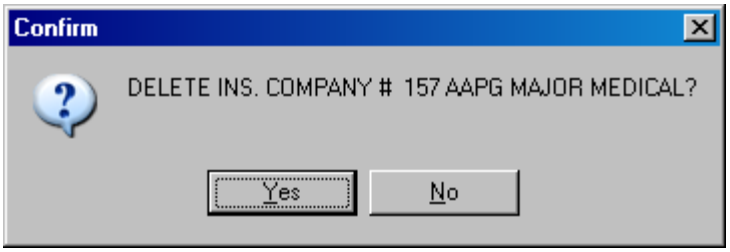
Delete Insurance Record



Enter **last name** or **ID#** and **<BROWSE>**.


Insurance Company Browser (Press F1 Key To See More Information, * = Inactive Record)
ID# Company Name Address
157|AAPG MAJOR MEDICAL |CLAIMS DIVISION-WASHINGTON, DC 20037
103|AARP |CLAIMS DIVISION-PHILIDELPHIA, PA 191
441|AARP |CLAIMS DIVISION-LAKEWOOD, CA 90712
1025|AARP |CLAIMS DIVISION-WASHINGTON, DC 20049
851|AARP CLAIM UNIT |CLAIMS DIVISION-MONTGOMERYVILLE, PA
343|AARP HEALTH CLAIM DIVISIO |UNITED HEALTH CARE CLAIM-ATLANTA, GA
2072|ABB VETCO GRAY,INC EMP BN |C/O DBL SERVICES-ST LOUIS, MO 631775
1223|ACADIAN HEALTH CARE ALLIANCE |CLAIMS DEPT.-LAFAYETTE, LA 70505
1235|ACADIAN HEALTH CARE ALLIA |LINDA GUIDRY-CROWLEY, LA 70526
1884|ACADIAN HEALTH CARE ALLIA |CLAIMS-LAFAYETTE, LA 705051102
516|ACADIAN HEALTHCARE ALLIAN |ATTN:CLAIMS-LAFAYETTE, LA 70503
1238|ACADIAN HEALTHCARE ALLIAN |CLAIMS DEPT.-LAFAYETTE, LA 705051102
1320|ACADIANA HEALTHCARE ALLIC |CLAIMS DEPT.-LAFAYETTE, LA 705051102
1207|ACCESS CARE - BC/BS |P. O. BOX 98044-BATON ROUGE, LA 7089
1656|ACCOUNTABLE HLTH PLANS |600 SIX FLAGS DR ST 200-ARLINGTON, T
1810|ACI |CLAIMS DIVISION-ROCKWALL, TX 75087
1802|ACORDIA BENEFIT SERVICES |OF NORTHERN CALIFORNIA-SAN FRANCISCO
535|ACORDIA BENEFITS OF S IN |CLAIMS DIVISION-DULUTH, GA 301364958
998|ACORDIA INSURANCE COMPANY |CLAIMS DIVISION-LAFAYETTE, LA 70505
498|ACORDIA NATIONAL |CLAIMS DIVISION-CHARLESTON, WV 25337

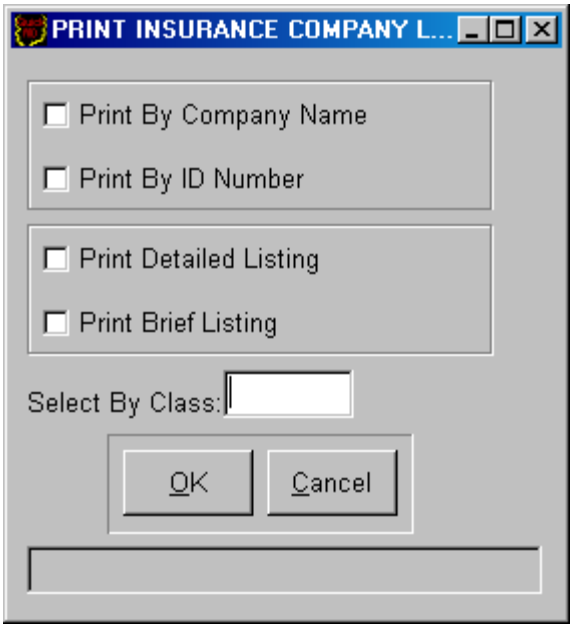
Choose record and hit **<ENTER>** or double click on record.



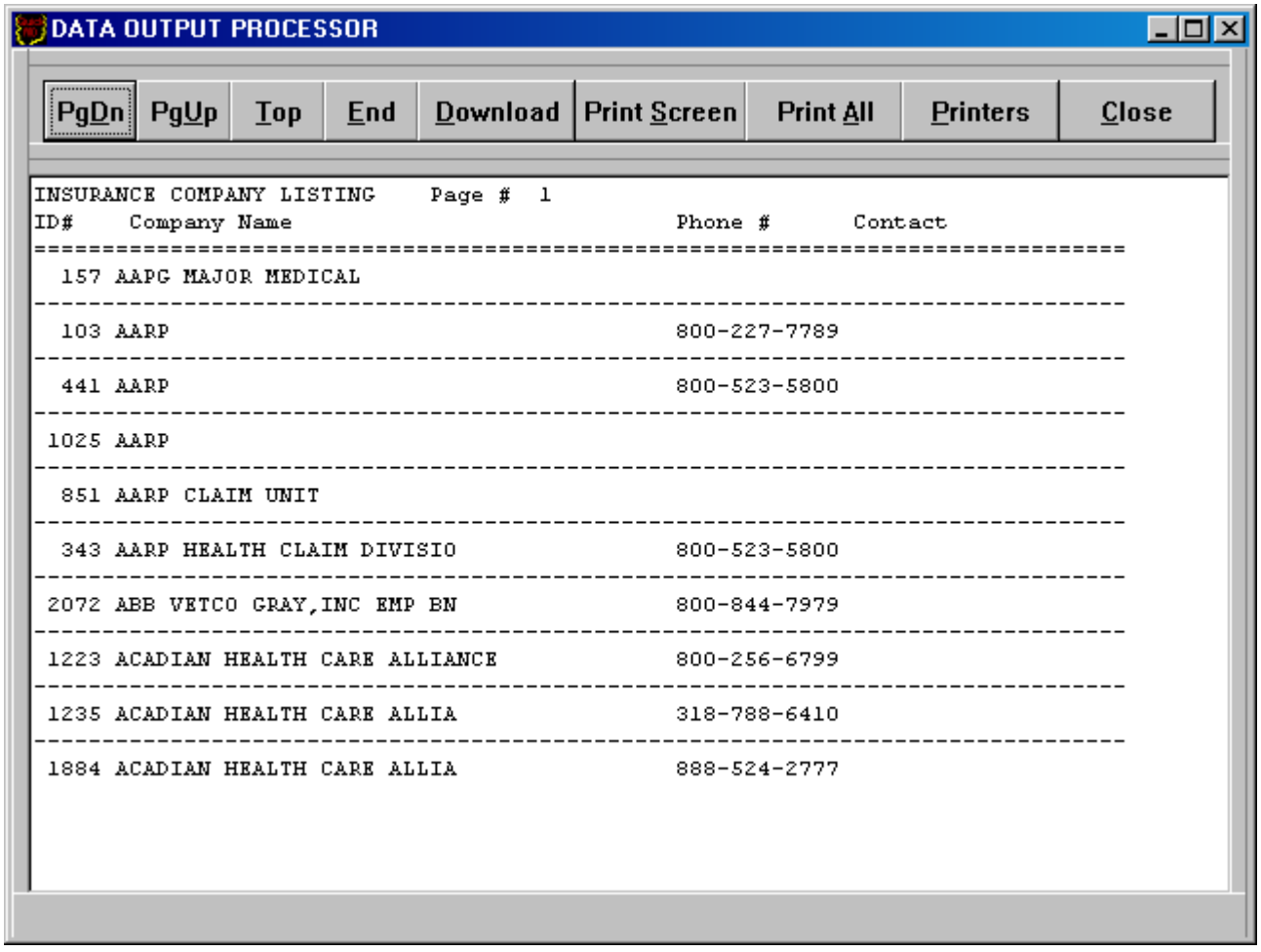
This screen confirms deletion of record. If you are sure you want to delete this record, choose **<YES>**. Otherwise, choose **<NO>**.

> ***NOTE:*** *Once deleted, a record cannot be recovered.*
>
> ***IMPORTANT:*** *DO NOT DELETE A RECORD IF IT HAS EVER BEEN USED IN A PATIENT FILE. IF YOU TRY AND FILE OR REFILE A CLAIM THE INSURANCE COMPANY INFORMATION WILL NOT BE AVAILABLE. THIS DELETE FUNCTION IS PRIMARILY USED DURING INITIAL SETUP OF THE TABLES.*

Print Report



Select Print Order, Report Enter and **<OK>**

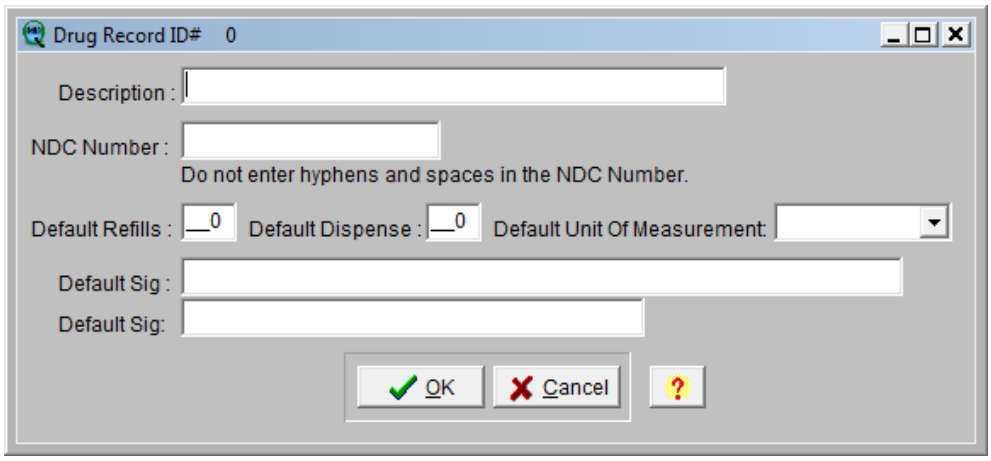


From the **DATA OUTPUT PROCESSOR**, you can either download or print the report.

Drug Table

This table maintains all of the Drugs you prescribe using the prescription module in Quick-MD *(for more information see page 208)*. Use this feature to add, edit and delete your Drug Records.

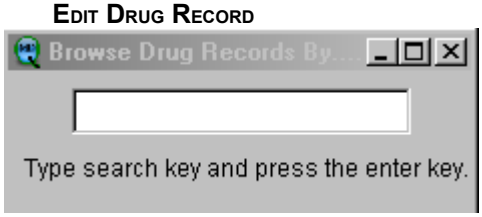
Add Drug Record



Type in the Description of the drug you wish to add.
Type in the Default Refills, Dispense amounts and Default Sig for the drug you are adding and hit **OK**.

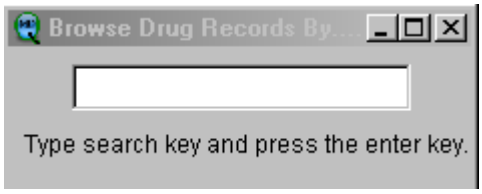
If you are going to be billing procedures associated with this drug then you will need to fill out the NDC number, Default Dispensed and the Default Unit of Measurements. You can setup the Default Unit Of Measurements in properties. *(See Page 96)*

Edit Drug Record



Type in the name of the drug you wish to edit. When the description box comes up simply edit the drug and hit **OK**.

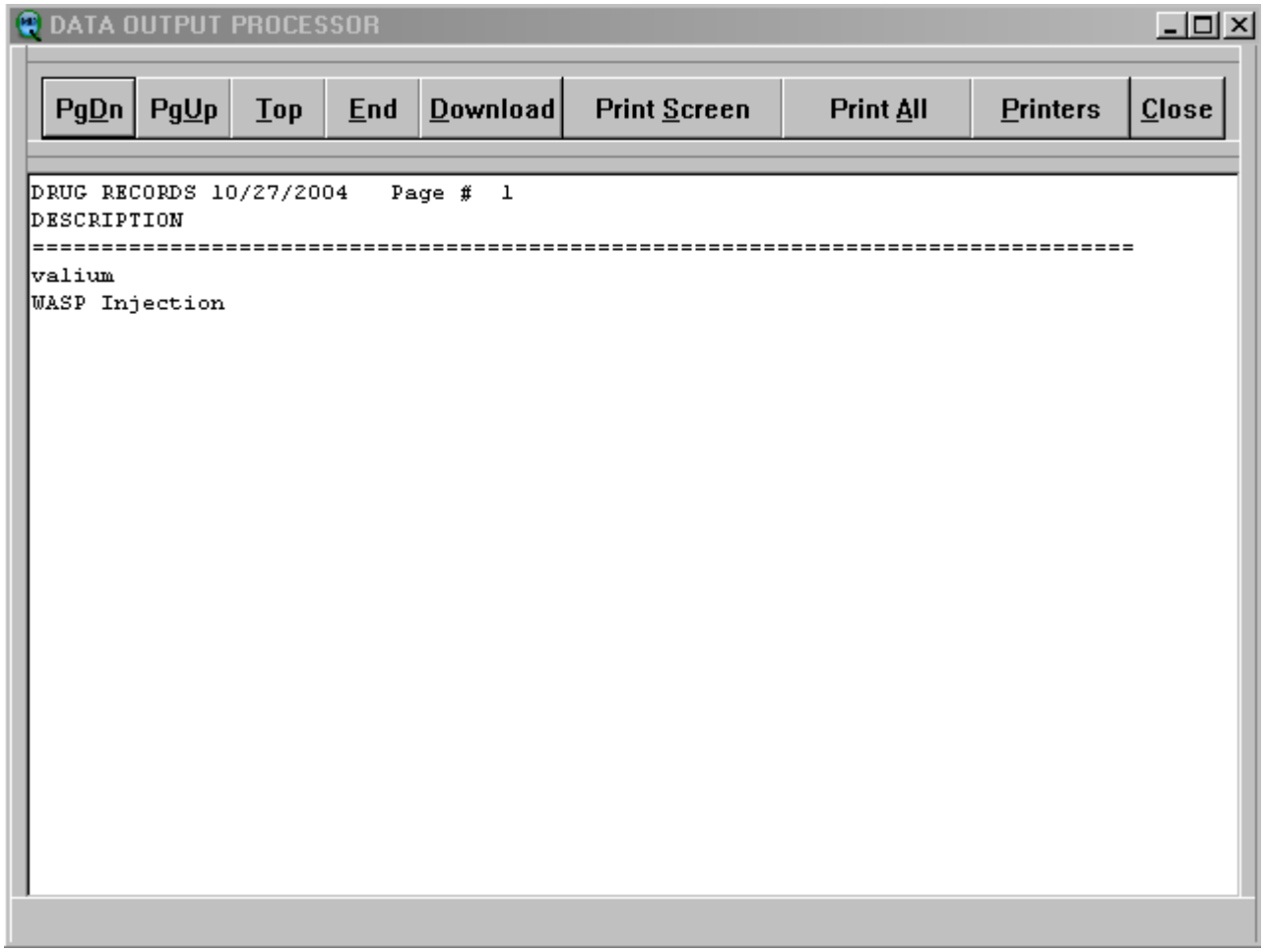
Delete Drug Record



Type in the name of the drug you wish to delete and hit **OK**.

Print Report

Use this feature to print a report of all the drugs you have added to Quick-MD.

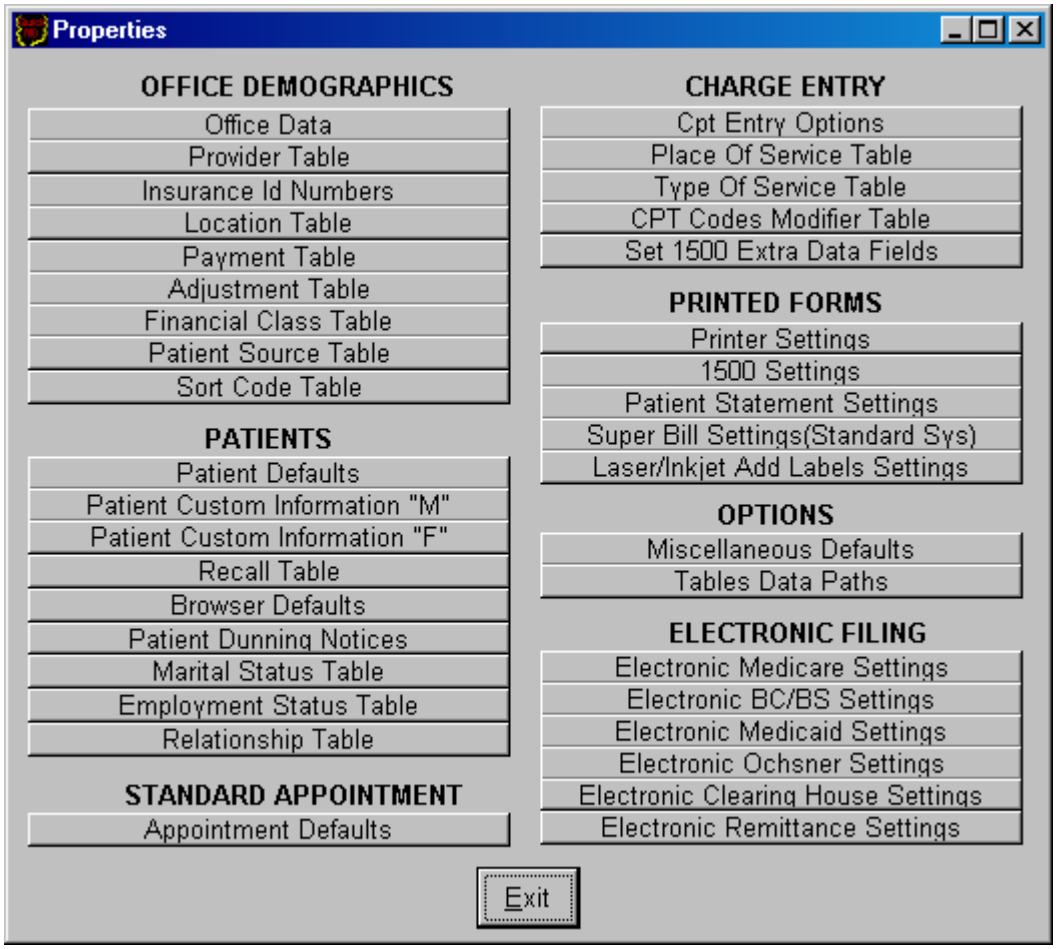

DATA OUTPUT PROCESSOR
PgDn
PgUp
Top
End
Download
Print Screen
Print All
Printers
Close
DRUG RECORDS 10/27/2004 Page # 1
DESCRIPTION
valium
WASP Injection

CUSTOMIZING QUICK-MD - THE PROPERTIES MENU

The properties menu is used to set up and configure Quick-MD to the way you want to run your practice. When setting up Quick-MD for the first time, you will go through each of these menu items and fill them in with information that is appropriate for your practice. This section describes each of these options in detail.

IMPORTANT: *There should only be one Operator at a time in Properties!*

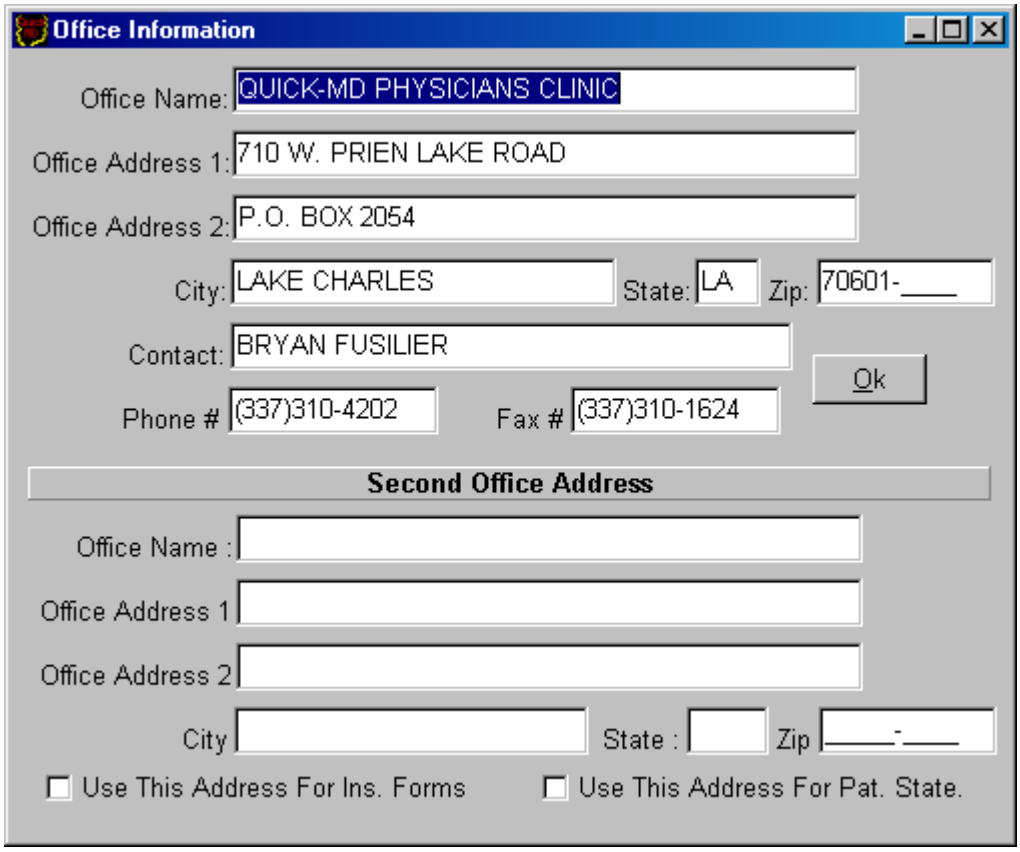
Getting there:
From the Quick-MD main menu, select ***PROPERTIES***



OFFICE DEMOGRAPHICS

OFFICE DATA

Use this feature to set up the practice location information that will be printed on all billing forms.



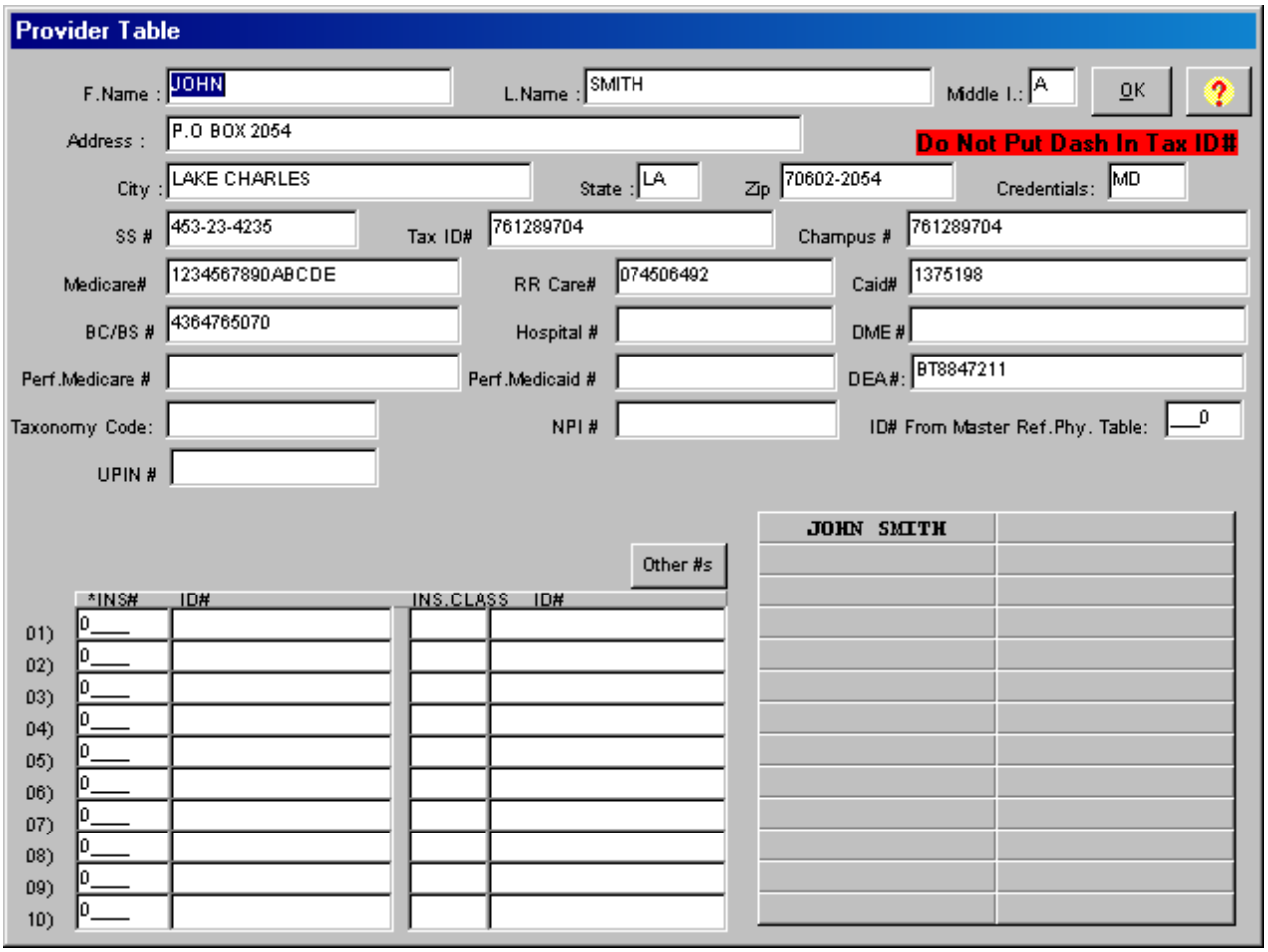
Second Office Address – This feature is optional. This field gives you the option to have this address used on the Insurance forms and/or for the Patient Statements in place of the primary address.

Use this Address for Ins. Forms – Checking this box forces Quick-MD to use the **Second Office Address** on all insurance forms.

Use this Address for Patient State - Checking this box forces Quick-MD to use the **Second Office Address** on all patient statements.

PROVIDER TABLE

Use this feature to add up to twenty-six Providers with their individual provider ID numbers. The data supplied in the Provider Table is used for billing purposes.



Ins. #/ID#

If an individual insurance company issues a provider a pin number, enter the id# of the insurance company from the insurance tables in the INS.# Field and the pin number issued to the doctor in the ID# field to have this number print on the 1500 form.

INS. Class/ID#

If you have the same insurance company in the master **Insurance Tables** multiple times with different addresses and **ID#'s**, and want the provider's PIN# to show up on all of their claims, you assign this payer a four digit class in the main **INSURANCE TABLES** and insert the number in the **"INSURANCE CLASS"** field. (ie. BCBS for Blue Cross). Put this "classification" in all of the like insurances in the main tables. Then in the **PROVIDER TABLES** you define this class and the provider's PIN# in the **INS. CLASS/ID#** field. Also, if you have a single payer that issues a provider a pin#, then simply enter that company's id# from the insurance table and his assigned number in the **INS ID#/ ID#** field. It will now print on the 1500 form. The Standard Scheduler also accesses this table for setting up books for scheduling patients.

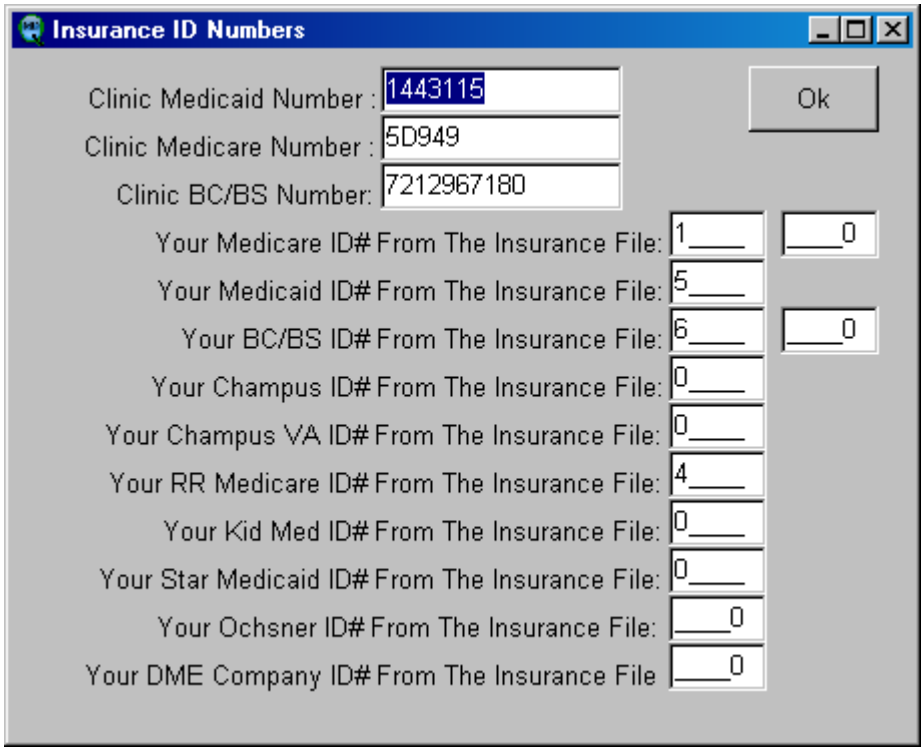
ID FROM REFERING PHYSICIAN TABLE –

Use this feature to set a default referring physician for this provider.

***Note:** The perf. Medicare and perf. Medicaid numbers are now deprecated.*

Insurance ID Numbers

If your practice bills as a clinic, then this feature allows you to define clinic numbers for Medicare, Medicaid, or Blue Cross. It is additionally used to identify the six major Insurance Plans that require Provider ID numbers. This table tells Quick-MD to pull the Insurance Plan ID numbers from the Insurance File for billing purposes on the HCFA1500.

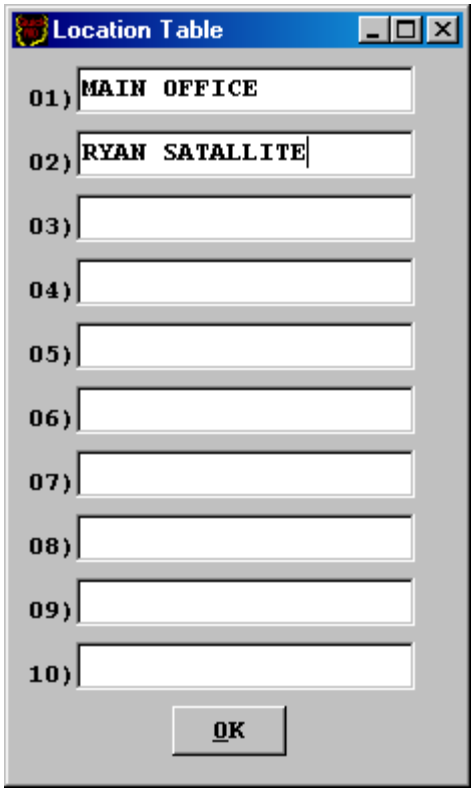

Insurance ID Numbers
Clinic Medicaid Number : 1443115
Clinic Medicare Number : 5D949
Clinic BC/BS Number: 7212967180
Ok
Your Medicare ID# From The Insurance File: 1___ ___0
Your Medicaid ID# From The Insurance File: 5___
Your BC/BS ID# From The Insurance File: 6___ ___0
Your Champus ID# From The Insurance File: 0___
Your Champus VA ID# From The Insurance File: 0___
Your RR Medicare ID# From The Insurance File: 4___
Your Kid Med ID# From The Insurance File: 0___
Your Star Medicaid ID# From The Insurance File: 0___
Your Ochsner ID# From The Insurance File: ___0
Your DME Company ID# From The Insurance File ___0

Steps:

1. If your Providers are billing electronically to Medicare and Medicaid, and use a clinic to bill all physician claims under, enter the clinic number for Medicare and Medicaid.
2. The other nine fields require the Insurance ID numbers, of each insurance listed, if applicable.

Location Table

This feature allows you to define up to ten locations where your practice performs service. (i.e. satellite locations) The selection is made when entering the patient demographics and during the charge entry process, and is for reporting purposes only.

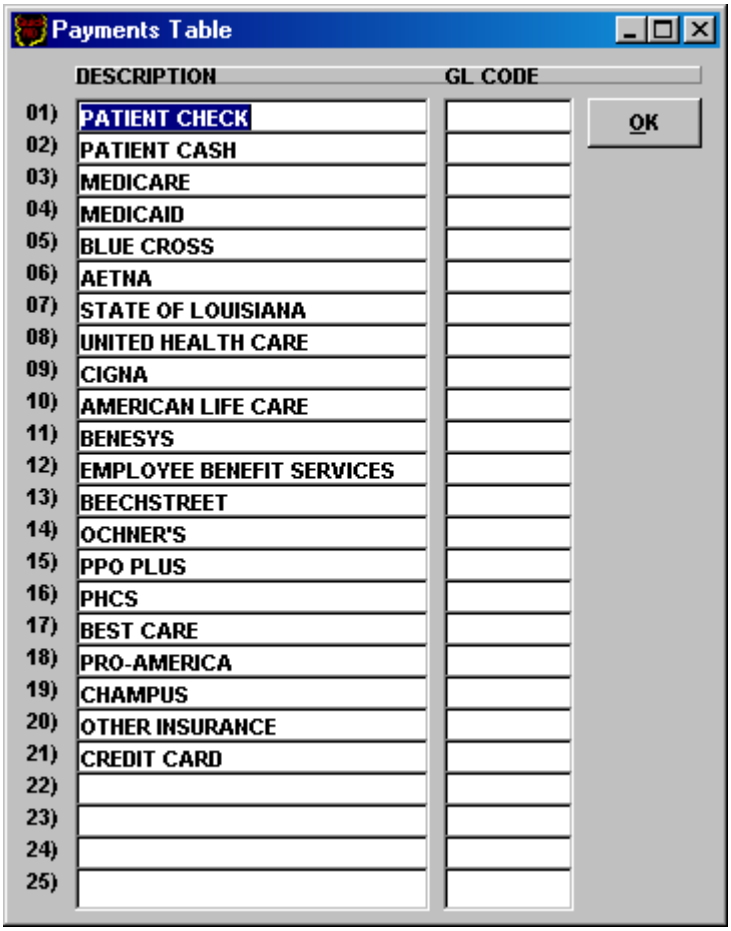


Note: *This table is strictly for reporting purposes and is different from the* ***Place of Service Table.*** *The* ***Place of Service*** *(for more information see page 82) is utilized on the 1500 form and is defined by HCFA.*

Payment Table

This feature allows you to define up to twenty-five description types for posting payments.
By posting payments according to description type, the user is able to generate numerous reports showing the revenue generated for each payment type. Generally speaking, self-pay payments types, government payers, BCBS, your 5 or 6 larger commercial payers, and a commercial or private insurance payment will give you all of the necessary types for in-dept reporting.

Example: *Patient Check, Patient Cash, Medicare Check, Medicaid Check, Blue Cross, Aetna, Cigna, Untied Healthcare, & Private Insurance Check. Maybe Workers Comp, Attorney's, or Liability if applicable.*



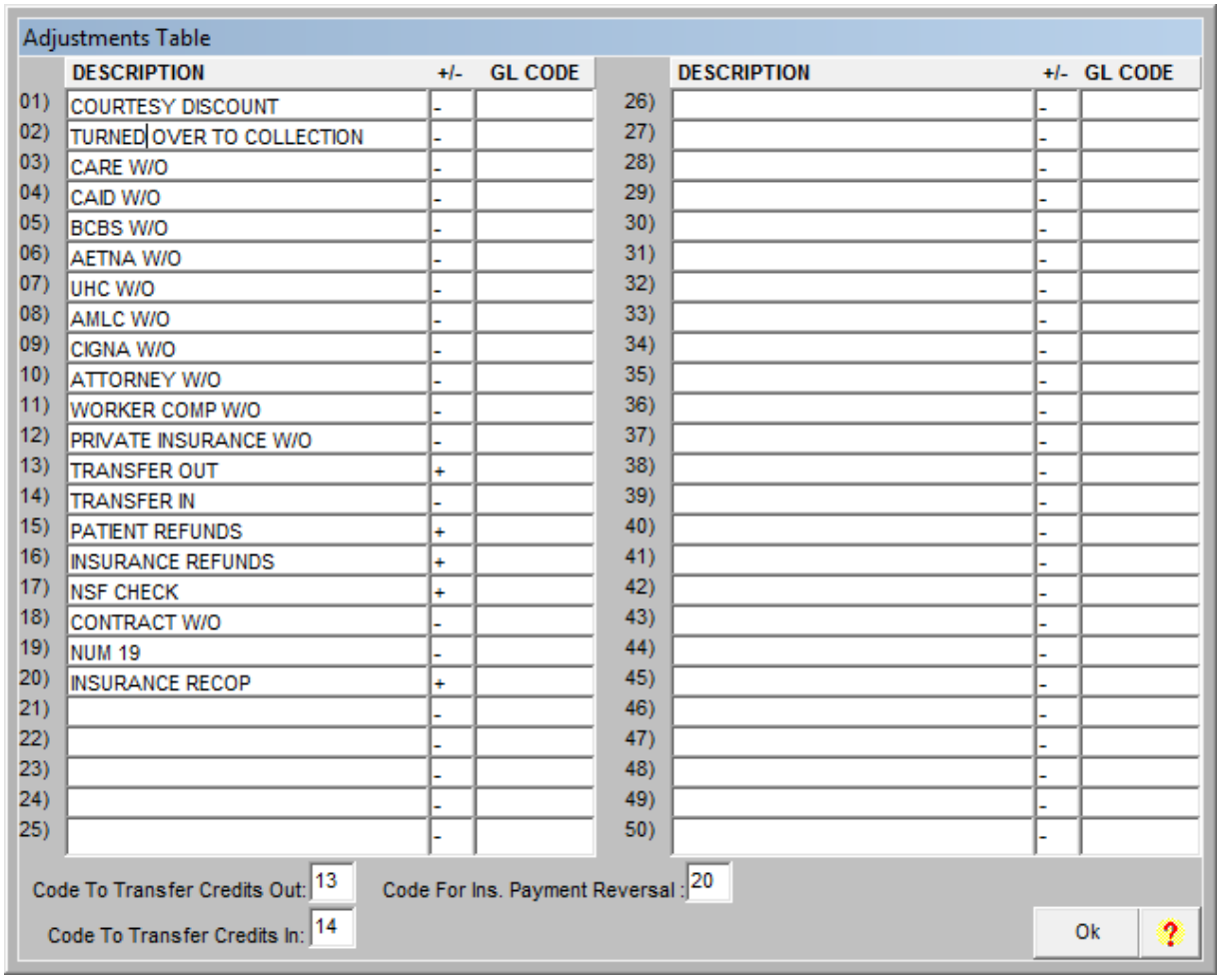
GL CODE - Use this feature to generate revenue totals by code. For instance, if a CPA firm prepares your financial statements or you use an accounting package in your office such as QuickBooks, Win books, Peachtree, etc., these codes would group the payment information by their GL codes.

> ***IMPORTANT:*** *When setting up the program for the first time you will want to try, in as much as it is possible, to have the entries in the Payment Table, The Adjustment Table and the Financial Class tables correspond to each other. For example, if Patient Check is setup in field one of the payment table, then you would want the number one position in the adjustment table to be a patient write off, and in the Financial class table, the first one would be self-pay. The reason being, that the desired selection may be brought in by simply entering the number of the desired selection and hitting the enter key. For example, if BCBS is number 4 in all tables, then when desiring to enter BCBS in the Financial class, payments or adjustments tables, simply enter the number 4, and hit enter to bring in BCBS. It is easier to remember the number if they are the same in all tables.*

ADJUSTMENT TABLE

This feature allows you to define up to twenty-five description types for posting adjustments.
By posting adjustments according to description types, the user is able to generate many meaningful reports to see how much money is being adjusted off.

> ***EXAMPLE:*** *COURTESY DISCOUNT, PROFESSIONAL DISCOUNT, MEDICARE WRITE-OFF, MEDICAID WRITE-OFF, BCBS WRITE OFF, AETNA, ETC. After your major payers you will want to enter PRIVATE INSURANCE WRITE-OFF, TRANSFER IN, TRANSFER OUT, PATIENT AND/OR INSURANCE REUND, NSF CHECK, ETC.*



"+"/ "-": This determines whether the adjustment moves money "into" or "out of" a patients ledger. Enter a "**+**" to add money to the patient ledger (or increase the amount of money he owes the office). Enter a **–** to entries that will decrease the patient's account receivables. Keep in mind that all refunds and NSF's will carry the "+" as it will need to add back to the ledger in order to zero it out.

CODE For Ins. Payment Reversal – Enter the number that you wish to use for your insurance recoup adjustment. If this code is set, when entering a negative payment on the Insurance payments by Invoice Screen, an adjustment of the type defined will be entered into the ledger.

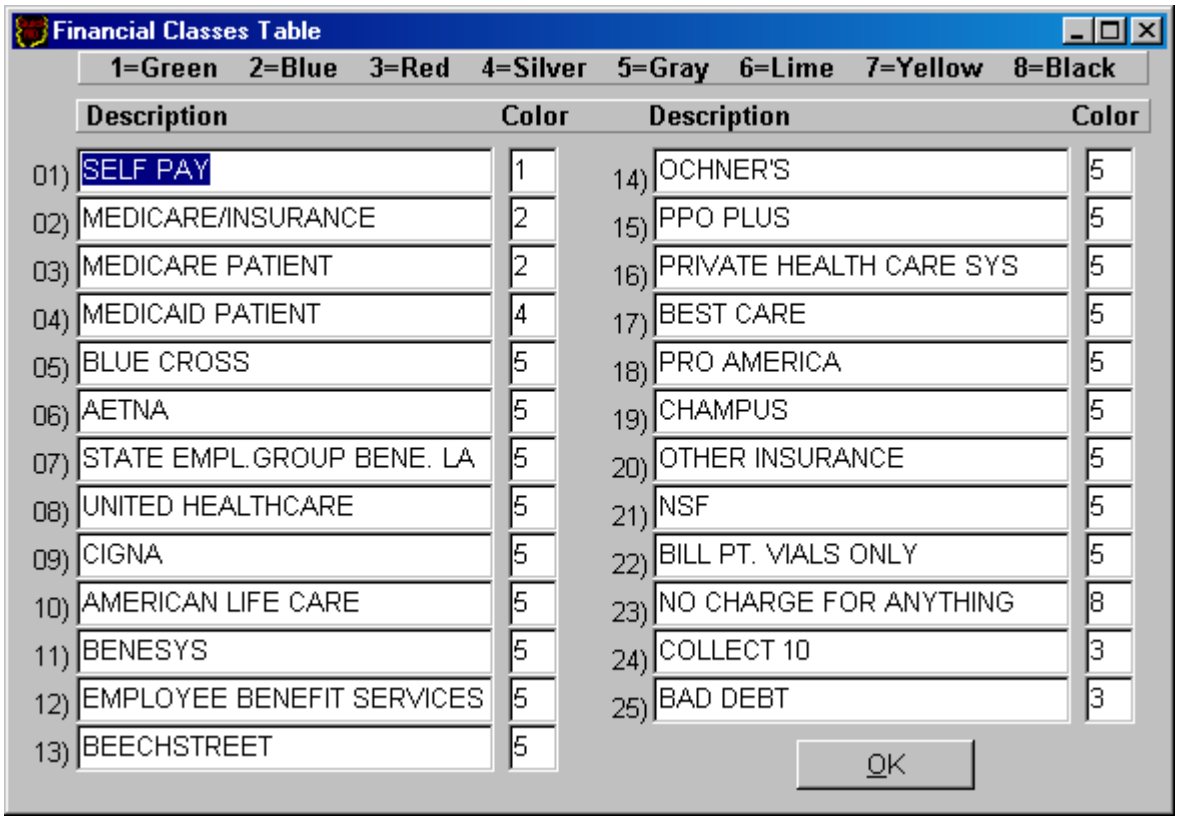
GL CODE- Use this feature to generate adjustment totals by code. For instance, if a CPA firm prepares your financial statements or you use an accounting package in your office such as QuickBooks, Win Books, Peachtree, etc., these codes would group the adjustment information by their GL codes for entry into the General Ledger of your accounting software.

> ***IMPORTANT:*** *When setting up the program for the first time you will want to try, in as much as it is possible, to have the entries in the Payment Table, The Adjustment Table and the Financial Class tables correspond to each other. For example, if Patient Check is setup in field one of the payment table, then you would want the number one position in the adjustment table to be a patient write off, and in the Financial class table, the first one would be self-pay. The reason being, that the desired selection may be brought in by simply entering the number of the desired selection and hitting the enter key. For example, if BCBS is number 4 in all tables, then when desiring to enter BCBS in the Financial class, payments or adjustments tables, simply enter the number 4, and hit enter to bring in BCBS. It is easier to remember the number if they are the same in all tables.*

FINANCIAL CLASS TABLE

Financial Classes allow you another way of grouping and viewing your patients. This time you are grouping by

your practices major payers. Defining meaningful financial classes allows you to run powerful reports on where your money is coming from.



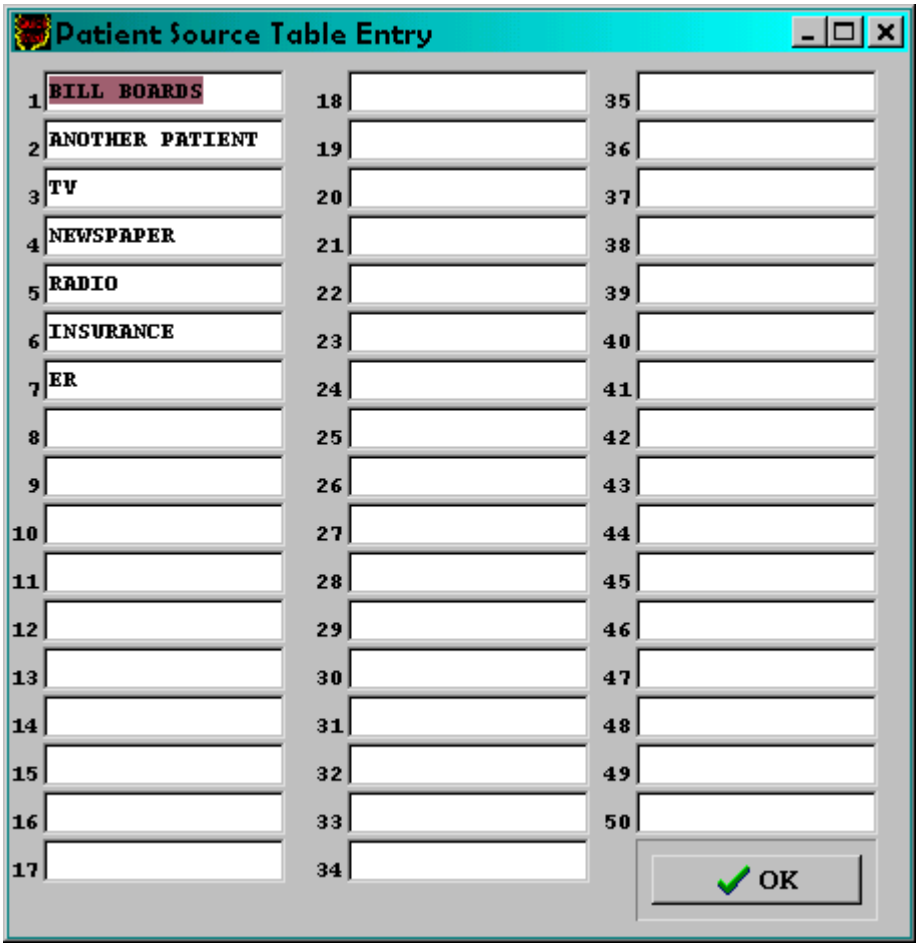
Note: *This table is used for reporting purposes only. It is designed to give the office reporting by financial classifications.*

Description – Enter the names of your major payment sources, ie. Self Pay, Medicare, Medicaid, Blue Cross, 5 or 6 Major Insurance companies, Commercial/Private Insurance, Attorney's, Worker Comp. etc.. You can define up to twenty-five pay classifications.

Color – This feature allows you to define a color code for each financial class. These colors will be visible in the **Patient Files Browser** *(for more information see page 212)* so that you can visibly see the Patients Financial Class when browsing for them.

Important: *When setting up the program for the first time you will want to try, in as much as it is possible, to have the entries in the Payment Table, The Adjustment Table and the Financial Class tables correspond to each other. For example, if Patient Check is setup in field one of the payment table, then you would want the number one position in the adjustment table to be a patient write off, and in the Financial class table, the first one would be self-pay. The reason being, that the desired selection may be brought in by simply entering the number of the desired selection and hitting the enter key. For example, if BCBS is number 4 in all tables, then when desiring to enter BCBS in the Financial class, payments or adjustments tables, simply enter the number 4, and hit enter to bring in BCBS. It is easier to remember the number if they are the same in all tables.*

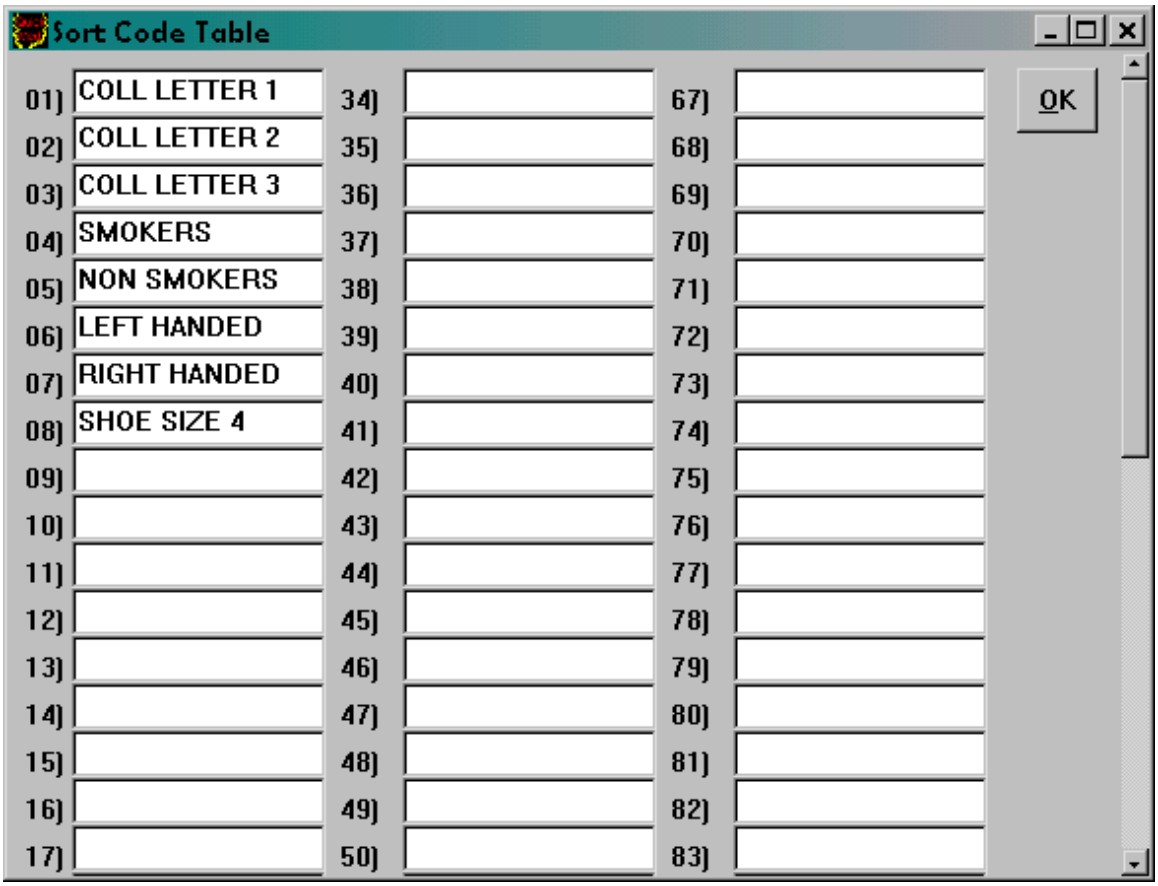
Patient Source Table



This feature allows you to list up to fifty Patient Source types. This data allows the office to track how Patient's became aware of their practice. It also allows for tracking and reporting on which marketing avenues are providing the most success.

Sort Code Table

Use this feature to define up to ninety-nine Sort (report codes) Codes to further classify patients for reporting and business management purposes. You may assign up to 3 sort codes per patient for reporting purposes. For instance, you could tell how many left handed, red headed, shoe size 4 women were in your database!



***Example:** Could be used to sort patients who are smokers and nonsmokers.*

You will also use sort codes to assist in your collection process. Set up three codes called “Collection Letter 1”, “Collection Letter 2” and “Collection Letter 3”. *(For more information on Generating Collection Letters, see **Mail Merge** on page 253)*

***Note:** Sort Codes are also utilized when doing reoccurring billing. (For more information see page 292)*

Patients

Patient Defaults

Use this feature to set up the default fields on the **Patient’s Demographics Screen**. This saves time when setting up new patients in the system. When adding patients that fall outside of these defaults, you can simply overwrite the default values with that of the patient you are entering.

City – Enter the default city name.

State – Enter the default State.

Zip – Enter the default zip code.

Default Area Code – Enter the default Area code.

Default Sex – Enter the default sex.

Default Provider – Enter the number of default provider from the provider tables.

Default Financial Class– Enter the default financial class.

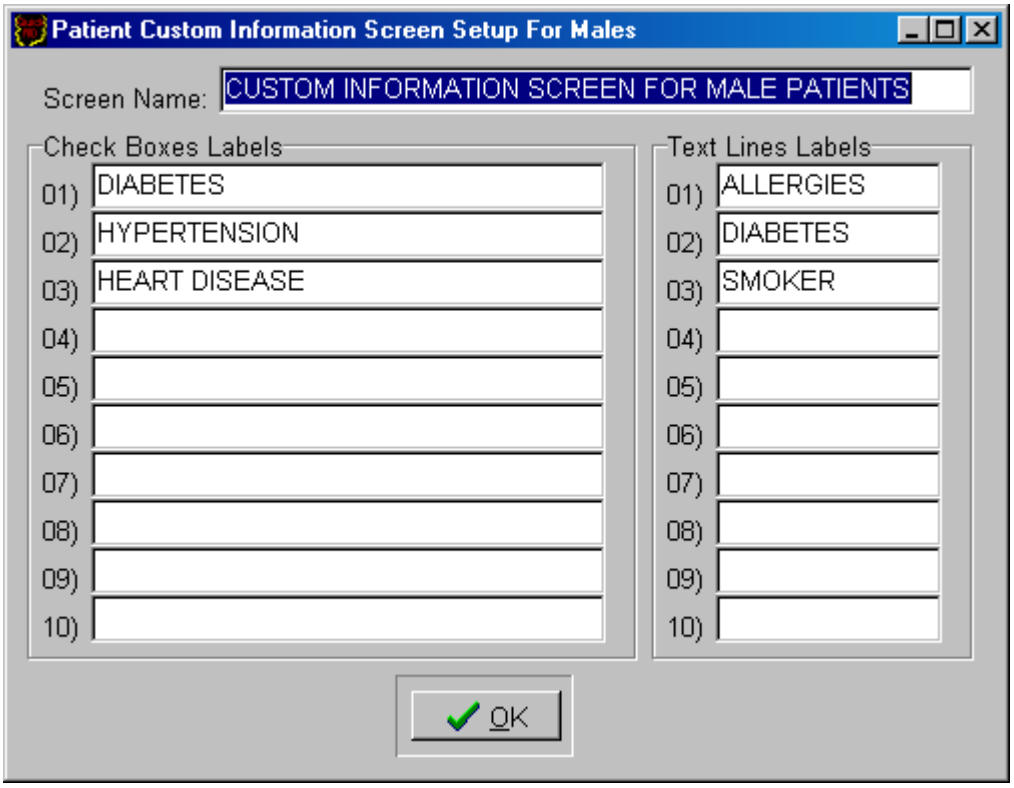
Accept Assignment – Applies to Medicare only. Use this feature to always accept the Medicare assignment.

Signature is On File - Check if you want the **Signature on File** to default to Yes.

Loop Patient File Creation Option – When checked, the **Lookup Patient File** *(for more information see page 211)* with always open after you exit a patient's demographic screen.

Patient Custom Information - Male

Use this feature to define the field names for any custom information you wish to track for your male patients.



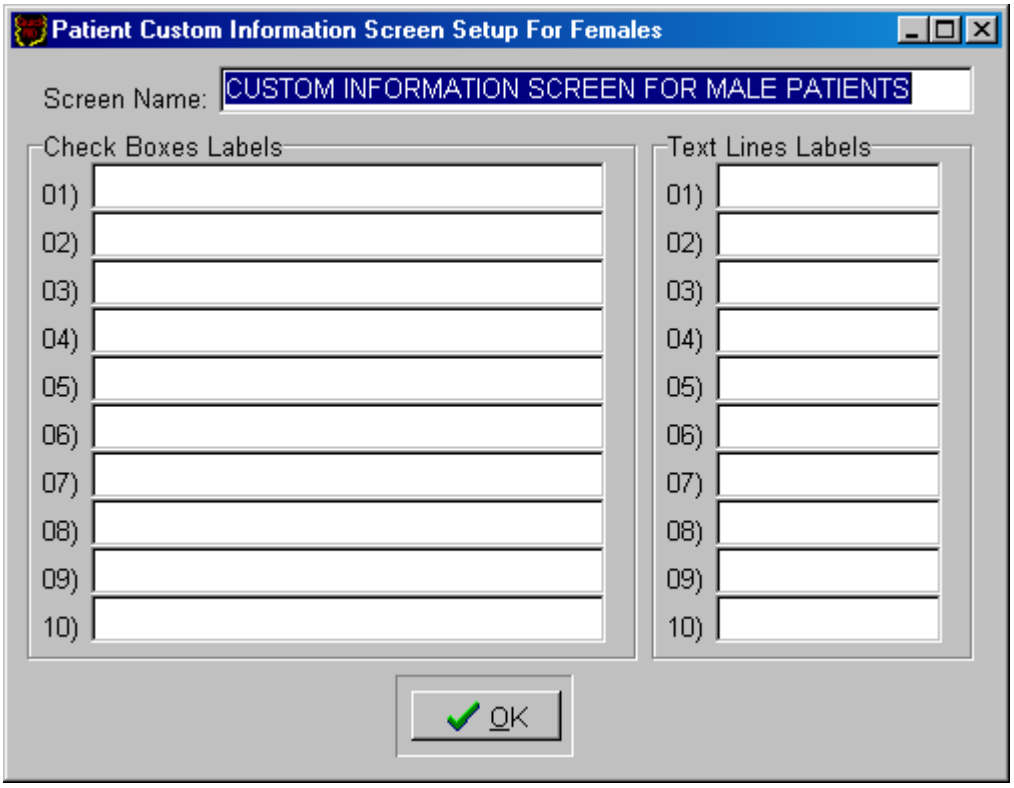
Screen Name: Choose a name to identify your custom screen .i.e. Family History or Patient History

Check Box Labels: Enter up to 10 descriptions for custom check boxes. These will be yes or no (true or false) answers to information you wish to tract on male patients. .i.e. - diabetes, hypertension, heart disease, or maybe tests you want to track results, etc.

Text Lines Labels: Enter up to 10 descriptions for custom text lines. These fields will allow the office to type up to 70 characters into each field for tracking information on each patient.

Patient Custom Information - Female

Use this feature to define the field names for any custom information you wish to track for your female patients.

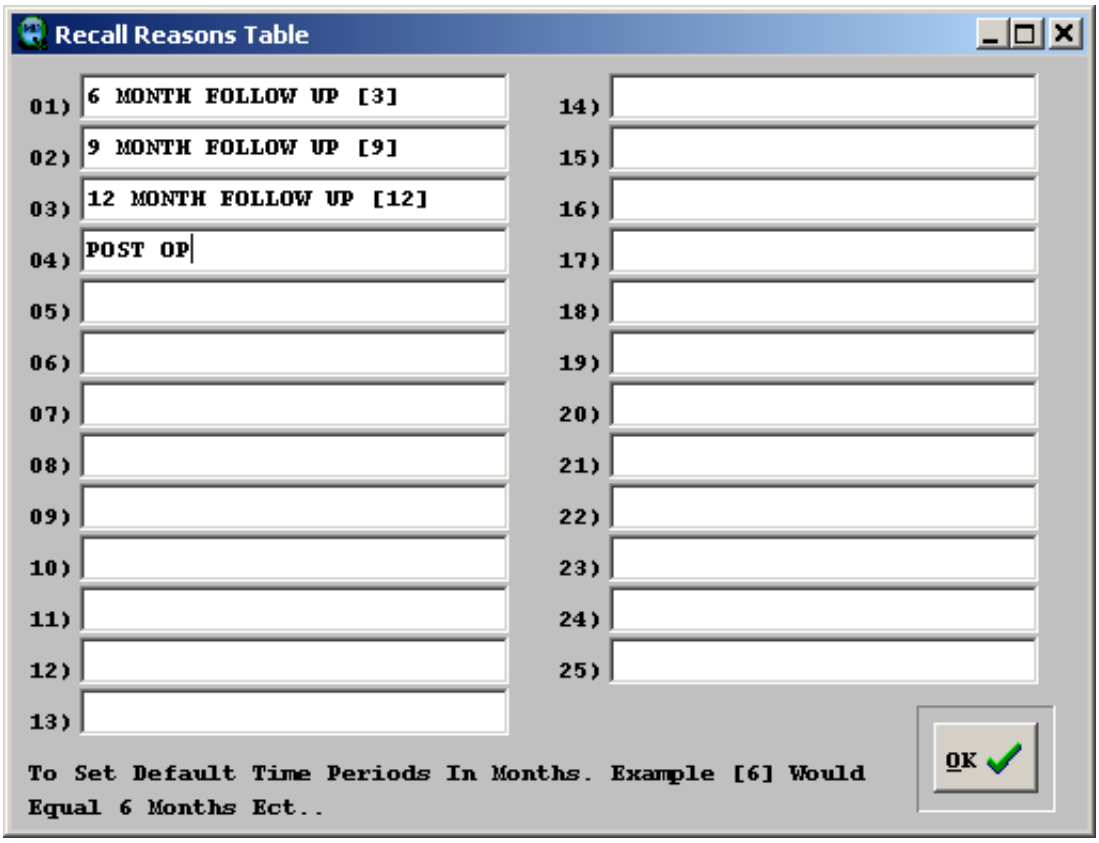


Screen Name: Choose a name to identify your custom screen. i.e. Patient History, Family History

Check Box Labels: Enter up to 10 descriptions for custom check boxes. These are yes or no (true or false) answers to information that you wish to track on your female patients.

Text Lines Labels: Enter up to 10 descriptions for custom text lines. These fields will allow for up to 70 characters to be typed in for tracking info or results.

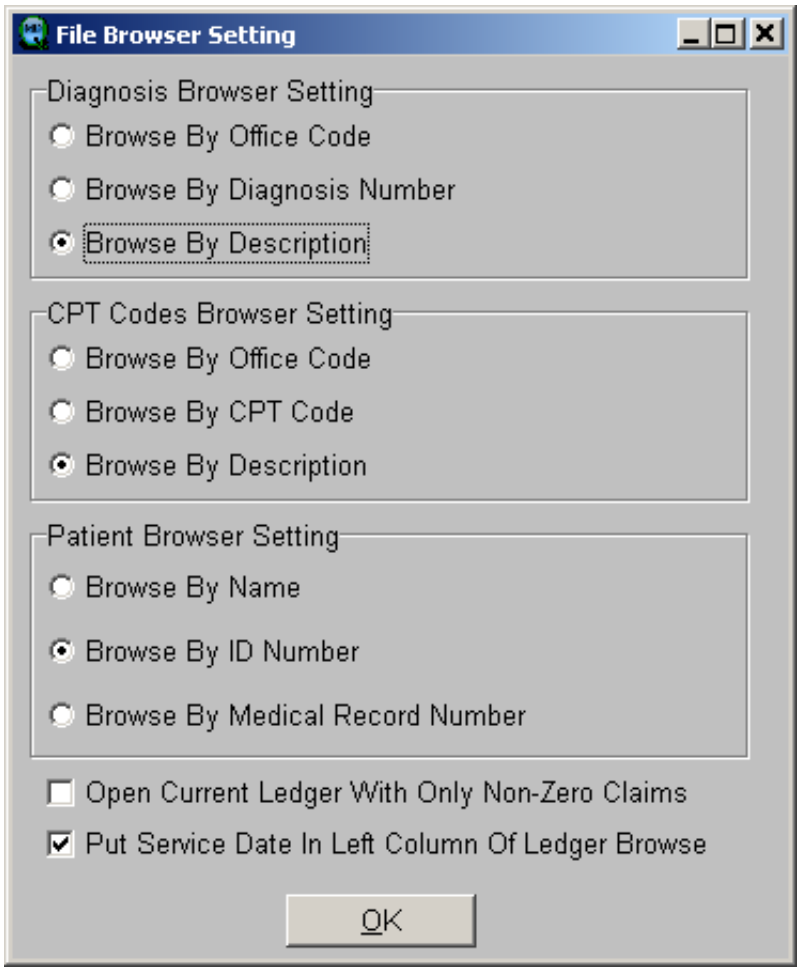
RECALL TABLE



This feature allows you to list up to twenty-five reasons for Patient Recall appointments. You can have the date for a certain recall automatically calculated by adding the number of months in square brackets at the end of the description. *(for more information see page 185)*

Browser Defaults

Use this feature to set the **Default Search Field** (the place where your cursor will always show up in first) when browsing the **Diagnosis Table**, **CPT Code Table** or **Patient Files**.


File Browser Setting
Diagnosis Browser Setting
Browse By Office Code
Browse By Diagnosis Number
Browse By Description
CPT Codes Browser Setting
Browse By Office Code
Browse By CPT Code
Browse By Description
Patient Browser Setting
Browse By Name
Browse By ID Number
Browse By Medical Record Number
Open Current Ledger With Only Non-Zero Claims
Put Service Date In Left Column Of Ledger Browse
OK

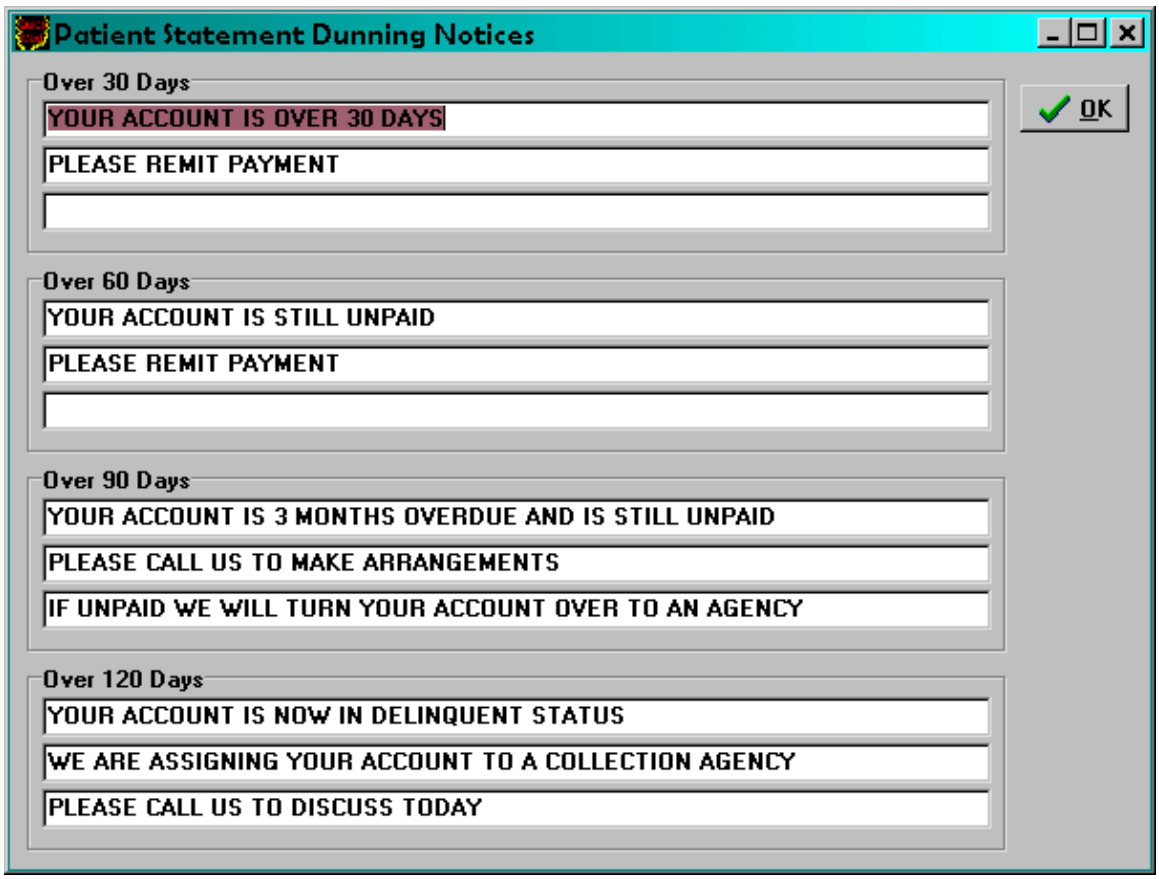
This feature gives the user flexibility when browsing, but does not exclude you from searching by any of the other fields. Simply move your cursor from the selected one to the one you are interested in.

Open Current Ledger With Only Non-Zero Claims – Use this feature to hide all Claims with a zero balance from being displayed when the current ledger is open.

> ***Note**: Whether this feature is turned on or off, you can still toggle the display of zero balance claims while in the ledger by hitting **<Shift> + <F4>.** (for more information see page 172)*

Put Service Date In Left Column Of Ledger Browse – Use this feature if you want the ledger browse to contain the “date of service” in the left column instead of the “ledger date”.

Patient Dunning Notices

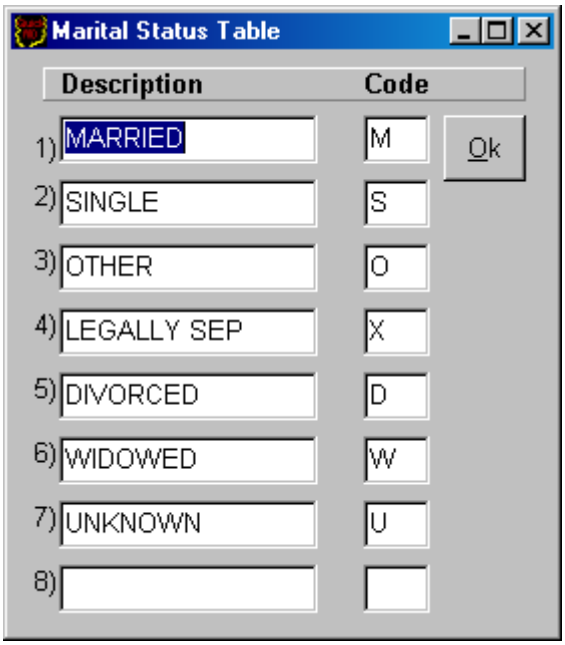

Patient Statement Dunning Notices
Over 30 Days
YOUR ACCOUNT IS OVER 30 DAYS
PLEASE REMIT PAYMENT
OK
Over 60 Days
YOUR ACCOUNT IS STILL UNPAID
PLEASE REMIT PAYMENT
Over 90 Days
YOUR ACCOUNT IS 3 MONTHS OVERDUE AND IS STILL UNPAID
PLEASE CALL US TO MAKE ARRANGEMENTS
IF UNPAID WE WILL TURN YOUR ACCOUNT OVER TO AN AGENCY
Over 120 Days
YOUR ACCOUNT IS NOW IN DELINQUENT STATUS
WE ARE ASSIGNING YOUR ACCOUNT TO A COLLECTION AGENCY
PLEASE CALL US TO DISCUSS TODAY

This feature allows you to print dunning messages on your Patient Statement for accounts over **30** days, over **60** days, over **90** days and over **120** days. The system will automatically decide which notice to put on the patients statement depending on the amount of time the account is past due.

> ***Note:*** *The data supplied in Patient Dunning Notices will be printed on Patient Statements for notification of past due accounts and will overwrite any global messages set in patient statements batch billing, if the patient is past due on their account.*

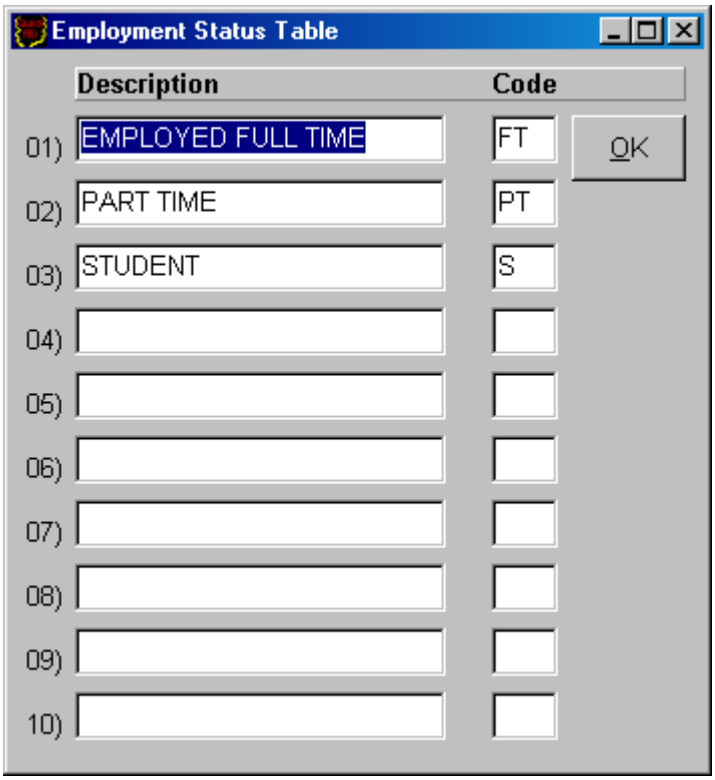
Marital Status Table

Use this feature to define up to eight Marital Status descriptions with the appropriate codes used for billing purposes as required and defined by HCFA.



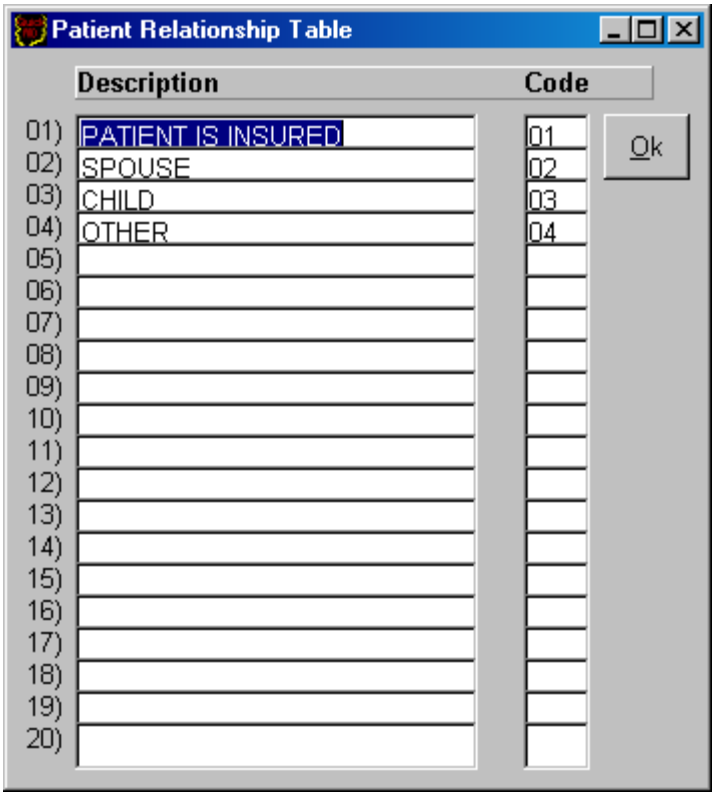
Employment Status Table

This feature allows you to define up to ten Employment Status descriptions types with the appropriate codes used for billing purposes as required and defined by HCFA.



Relationship Table

Use this feature to define up to twenty Patient Relationships to the subscriber of the insurance and the appropriate codes used for billing purposes as required and defined by HCFA.

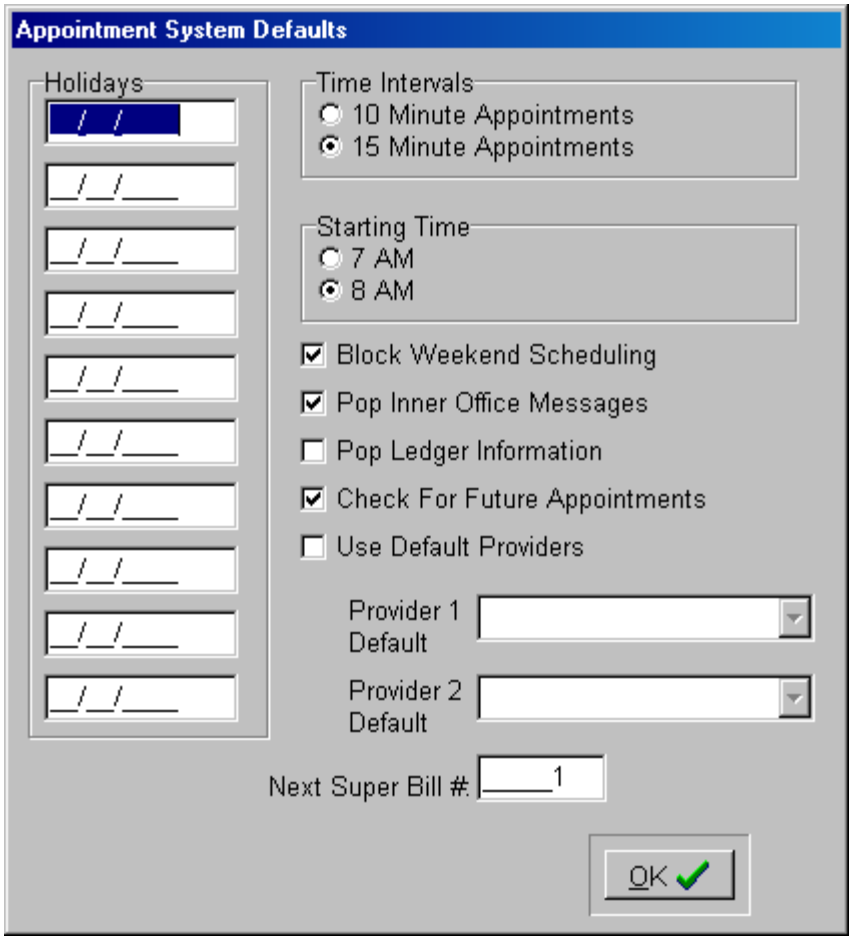


STANDARD APPOINTMENT

APPOINTMENT DEFAULTS

Use this feature to set APPOINTMENT DEFAULTS for the **STANDARD SCHEDULER ONLY**.

> ***IMPORTANT:*** *These defaults only apply to the **STANDARD SCHEDULER** (for more information see page 117). To configure the defaults of the **Q-SCHEDULER** you must open the **Q-SCHEDULER** and use the **SETTINGS** button. (for more information see page 114) To configure the defaults of the **MULTI-VIEW SCHEDULER** you must open the **MULTI-VIEW SCHEDULER** and use the **PROPERTIES** button. (for more information see page 124)*



Holidays - When trying to set appointments for the dates selected Quick-MD will pop a warning box.

Time Intervals - You can select 10 minute or 15 minute appointment intervals and Quick-MD will default all calendar days to the selected time intervals.

Block Weekend Scheduling - If selected, Quick-MD will pop a warning box when a user tries to schedule an appointment for a weekend.

Pop Inner Office Messages - **or Pop Ledger Information**: The system will display the inner office messages or information from the patient account, depending on which box is checked, when booking an appointment for an existing patient.

Check For Future Appointments - Quick-MD will look for existing appointments.

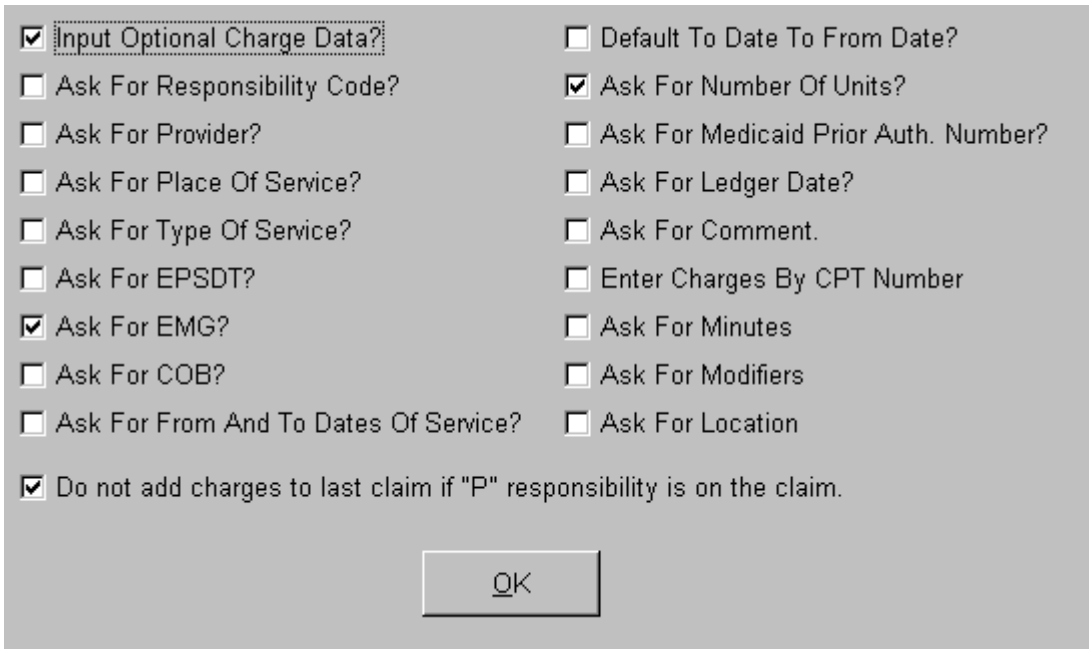
Use Default Providers - If selected, select a Provider for #1 default and #2 default. The appointment Calendar will default Book 1 and Book 2 to the selected default Providers.

Select the **<Ok>** button to save.

Charge Entry

Cpt Entry Options

Charge Entry Input Options allows you to control which fields the cursor stops in during the **Charge Entry** process *(for more information on **Other Charge Information** see page 165)*.

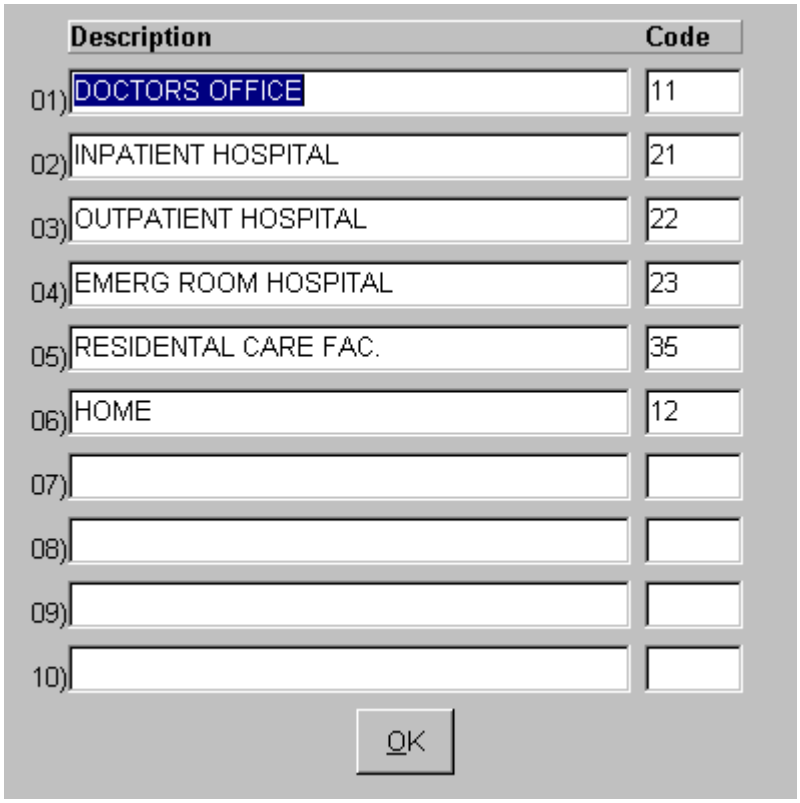

Input Optional Charge Data?
Default To Date To From Date?
Ask For Responsibility Code?
Ask For Number Of Units?
Ask For Provider?
Ask For Medicaid Prior Auth. Number?
Ask For Place Of Service?
Ask For Ledger Date?
Ask For Type Of Service?
Ask For Comment.
Ask For EPSDT?
Enter Charges By CPT Number
Ask For EMG?
Ask For Minutes
Ask For COB?
Ask For Modifiers
Ask For From And To Dates Of Service?
Ask For Location
Do not add charges to last claim if "P" responsibility is on the claim.
OK

NOTE: *To enable this feature you MUST select the first option, Input Optional Charge Data. Once this box is checked you can begin selecting the fields you want the cursor to stop in or skip over in the Other Charge Information Screen. For the fields you do not select to stop in, you will have to click that field to enter data.*

The last box labeled, **"Do not add charges to last claim if "P" responsibility is on the claim"** is used to define the action of the "Add charges to Last Claim" feature in the Ledger button found on the Patient demographics screen. When checked, if the last claim in the ledger has a "P" responsibility on it, Quick-MD will automatically create a new claim, to add these charges to, instead of adding them to a Patient Responsible claim.
(for more information see page 171)

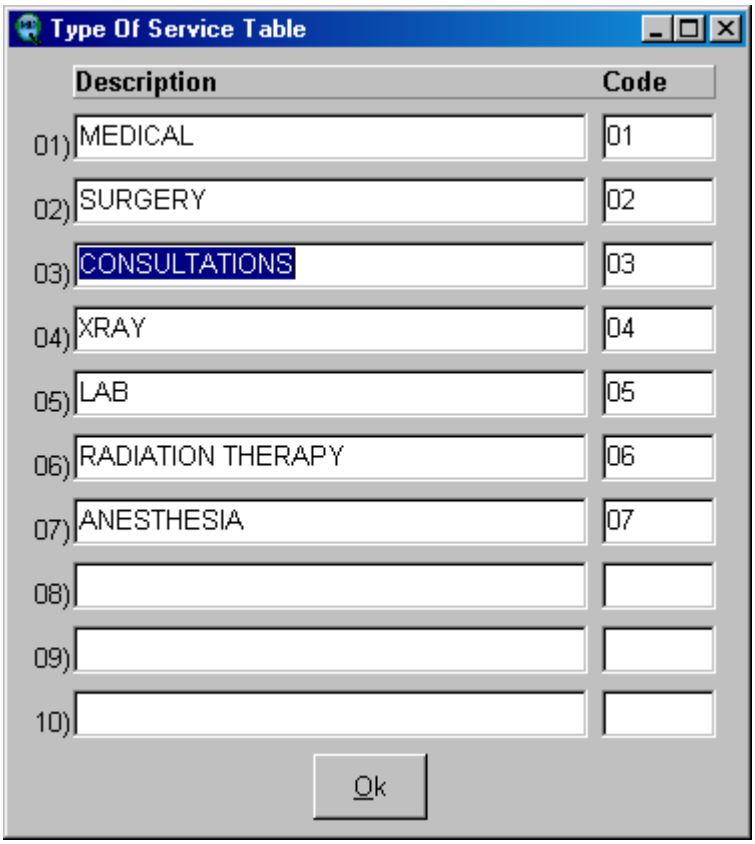
Place of Service Table

This feature allows you to define up to ten Place Of Service (POS) descriptions with the appropriate Service Code. The data supplied in the Place of Service Table is set as a default in the CPT Records to distinguish the place where services are rendered for that code. These POS codes are set by HCFA and must appear on the 1500 form.



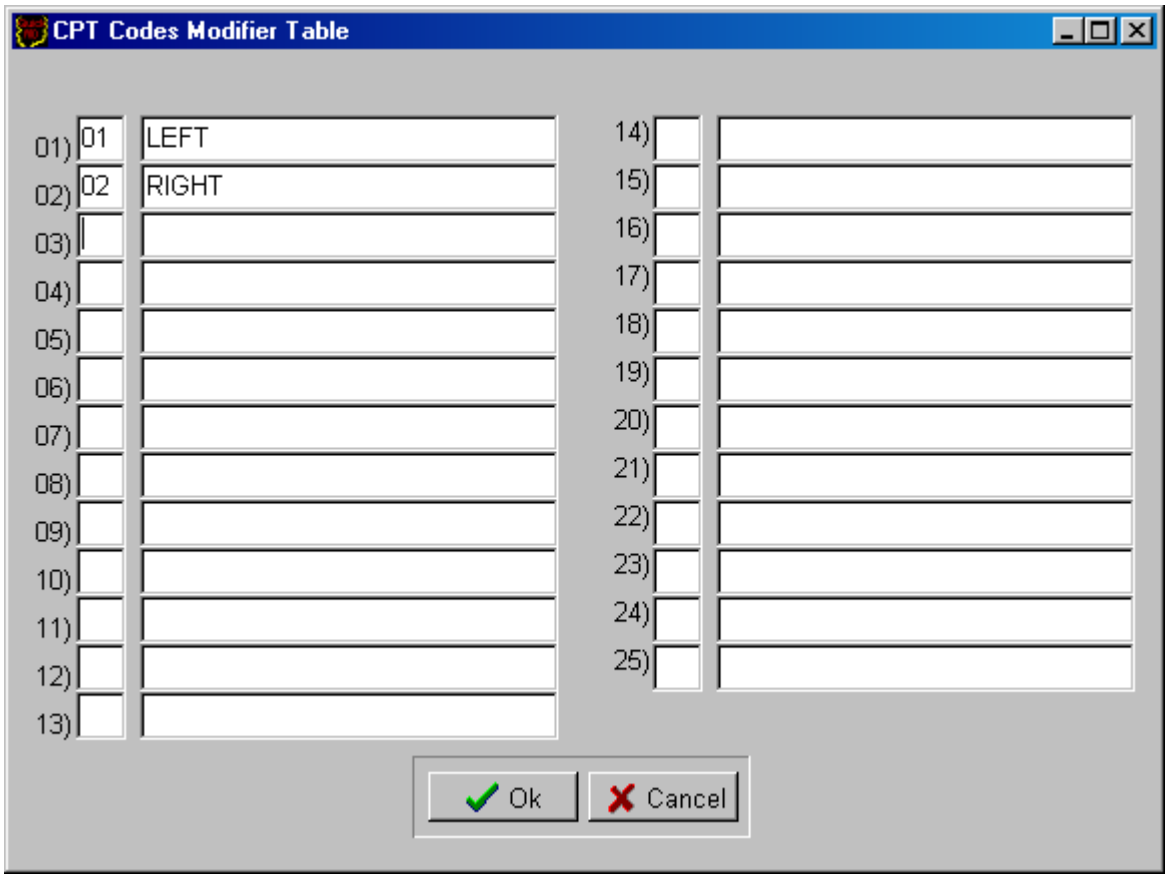
Type of Service Table

This feature allows you to define up to ten **Type Of Service** descriptions with the appropriate Type Code.



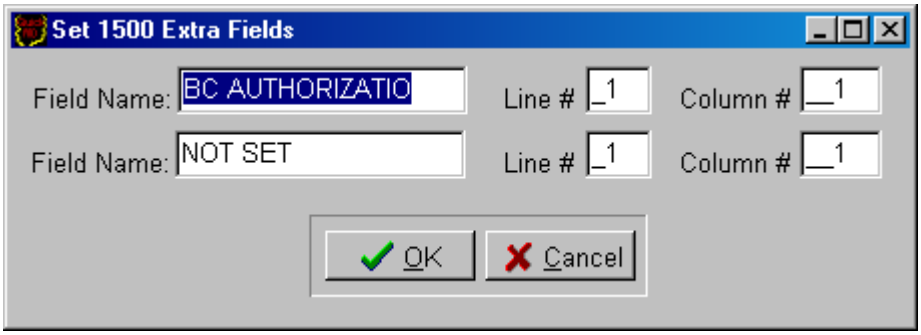
Note: *The data supplied in the Type of Service Table is used in the CPT Records to distinguish the Type of service being performed. These codes are set by HCFA and must appear on the 1500 form. They are set in this master table and then assigned to each CPT record, thereby defaulting to the proper TOS during the charge entry.*

Modifiers Table



This feature allows you to set up 25 modifiers and their descriptions. This table will be accessed during the charge entry process. The modifier fields on the "Other Charge Information Screen" are yellow fields and can be accessed with the **<F1>** key.

Set 1500 Extra Data Fields

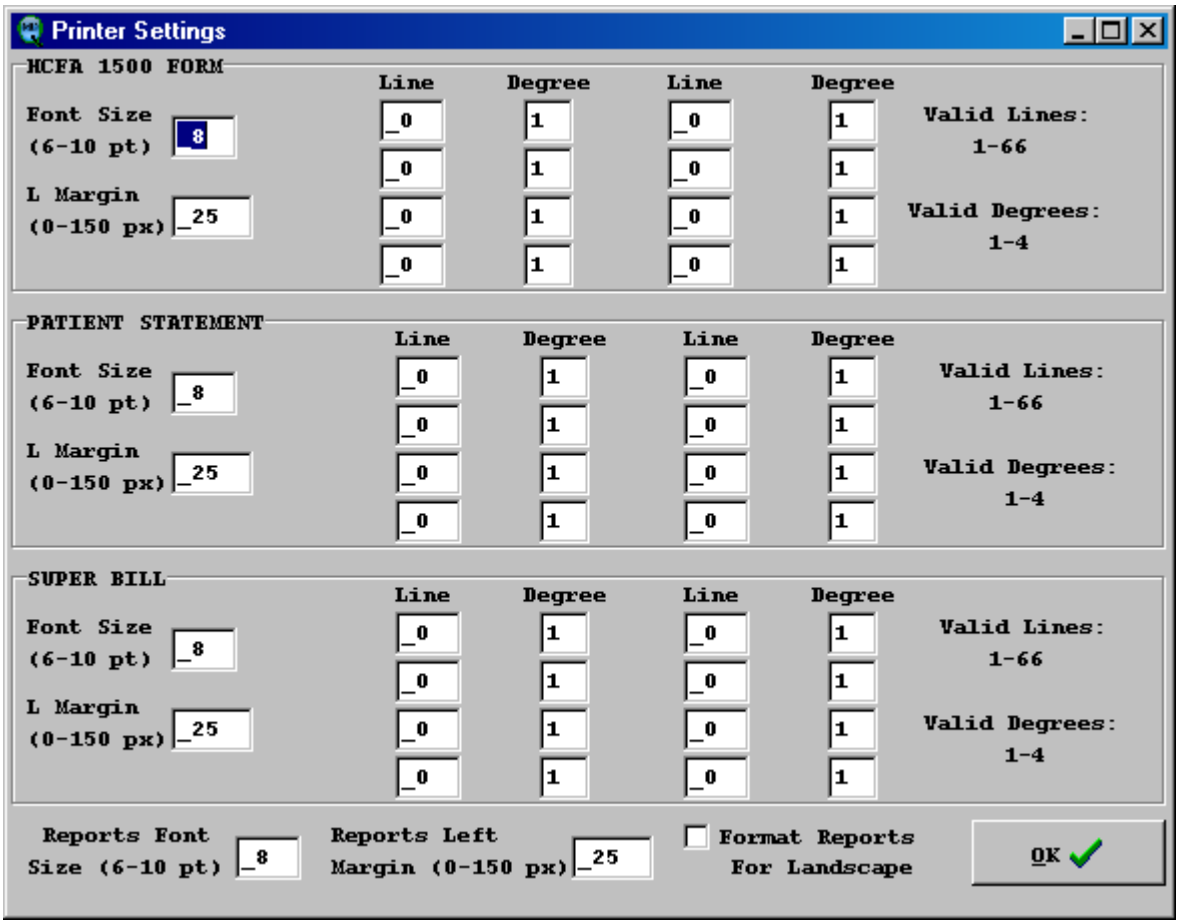


This feature allows you to define two extra blank fields on the 1500 form should a payer require additional information not currently on the 1500 form. Generate a grid from ***Properties/Printed Forms/1500 Settings/Print Grid***. Then align the 1500 form and the test grid and enter the corresponding column and line numbers where the payer wants it to print on the 1500 form. See **PRINTER SETTINGS (PROPERTIES MENU/ Printed Forms)** for up and down line adjustments. During the charge entry process, on the Supplier form, you will now see the new name of this field show up. Enter your required data here to have it print on the claim form.

Printed Forms

Printer Settings

This feature contains the Font Size and Left Margin for printing HCFA 1500 forms, Patient Statements, Super Bills, and Reports. It also allows you to format Reports for Landscape printing and to Dither, meaning the ability to lower information that is printing too high on a form. In Windows, different printers have different printer-drivers, therefore if you need more than one printer printing the forms, unless you are extremely lucky, you will need to have the same exact printer and printer drivers, as there is only one setting!



The test grid will represent the size of the Font being used, if you wish to change the size, simply enter the size desired into the **Font Size** field. Re-print the test grid.

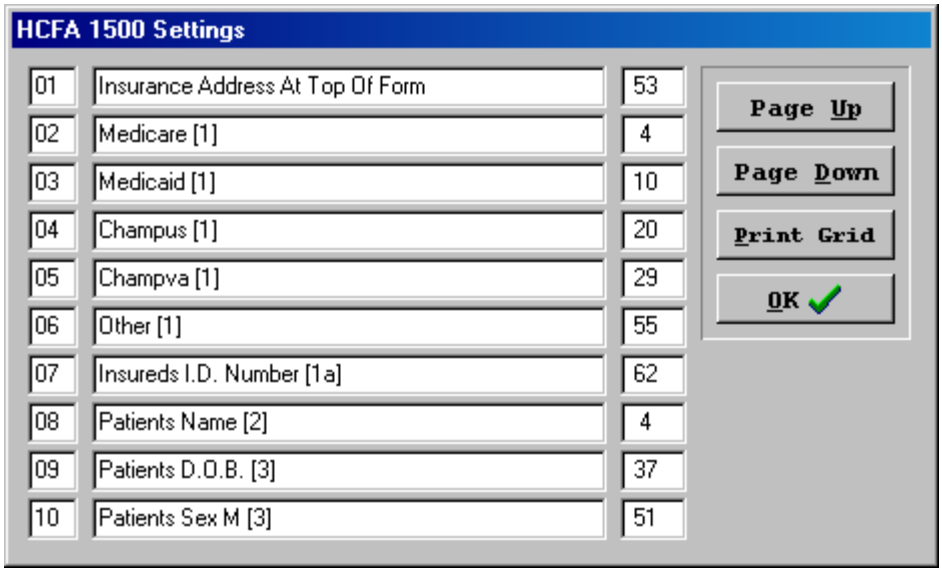
When you print your grid, and lay it over your form, if the left margin is too far to the left, increase the number in the **L. Margin** field and reprint the grid till you have moved it to the right enough.

If information is printing high on a form and needs to be lowered, the solution is referred to as “dithering”. Take the form that you have printed a test grid on and note the line number you wish to move downward, and the amount you wish it to be lowered. 1=whole line, 2=1/2 line, 3=1/3 line and 4=1/4 line.

> ***Important:*** *When a dither is inserted into a particular line, it moves all entries on the rest of the page down by the amount specified.*

HCFA 1500 Settings

Use this feature to setup Quick-MD to properly fill out your HCFA 1500 forms. This must be done prior to printing any 1500 forms.


HCFA 1500 Settings
01 Insurance Address At Top Of Form 53
02 Medicare [1] 4
03 Medicaid [1] 10
04 Champus [1] 20
05 Champva [1] 29
06 Other [1] 55
07 Insureds I.D. Number [1a] 62
08 Patients Name [2] 4
09 Patients D.O.B. [3] 37
10 Patients Sex M [3] 51
Page Up
Page Down
Print Grid
OK

Step One: Print a Test Form
Load your printer with your laser 1500 forms and then **<PRINT GRID>.** This will print the test grid out on your HCFA 1500 form.

USING THE TEST GRID
The test grid is how you will line up your 1500 forms, your Super Bills and your Patient Statements, so it is important that you understand how to correctly use it.

The grid is laid out as follows:

```
12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345
02xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
03xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
04xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
05xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
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24xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
```

The numbers across the top are the column numbers. They go from 1 to 0 (which equals 10) and then repeat again 1 to 0 for the next block of numbers. (i.e. 1-10, 11-20, 21-30, etc) It is helpful to pencil in the 10, 20, 30, 40 ,50 etc. across the top of the page. The numbers down the left hand side are line numbers.

You will take the form that you have just printed this grid on top of, and circle all of the "x's" that fall where you want your fields to print. This will tell you the exact line and column numbers that you will then plug into your coordinates of these fields.

> ***Trick:*** *Take a pencil and for each zero in the column row along the top of your grid, write the appropriate value that that zero carries. So over the first 0 you would write a 1 to signify that all the numbers following that zero are really 11,12, 13, 14. Over the second 0 you would write a 2 to signify that all the numbers following that zero are really, 21, 22, 23… Doing this allows you to easily see the "accurate" column number when plugging in coordinates.*
>
> ***Important:*** *If the left margin is off or information on your form needs to be shifted downward, these adjustments are made in* ***Printer Settings.*** *You will also set your font sizes here. (for more information see page 85).*

Step Two: Plug in your Coordinates

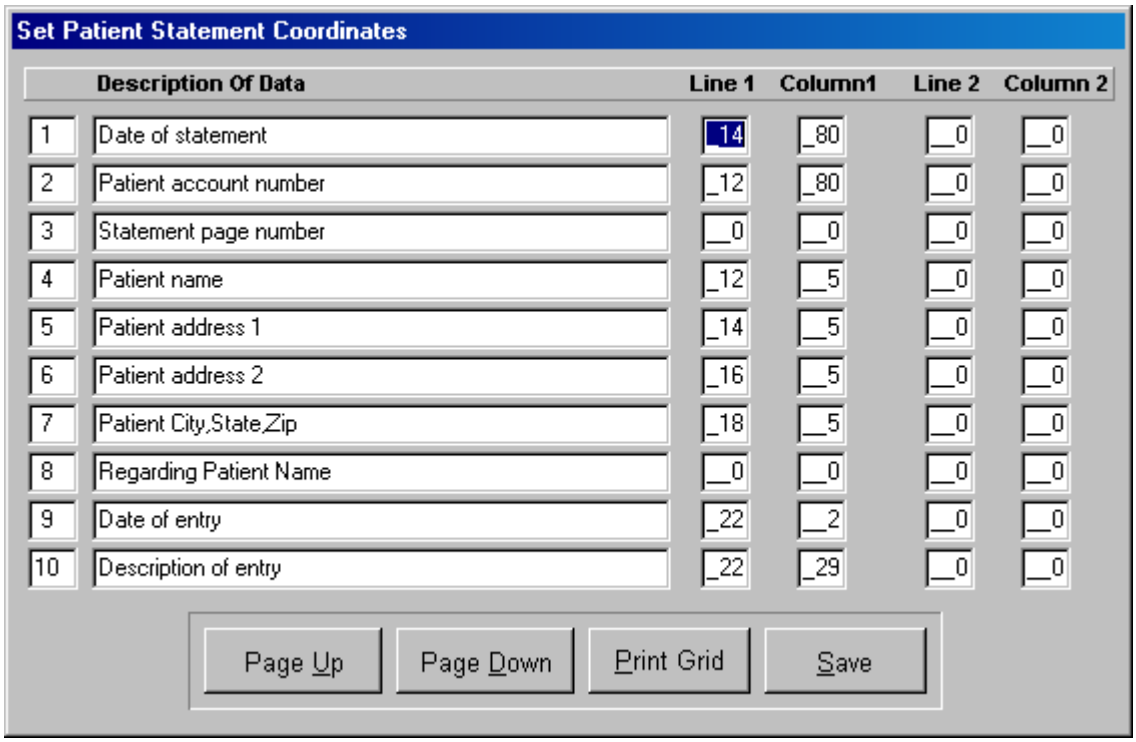
Now you can simply go through the list of fields and plug in the appropriate column number for each entry. Use the **<Page Up> <Page Down>** buttons to view the rest of the list.

> ***Important: Plot all of the coordinates on the 1500 form!***

Patient Statement Settings

Use this feature to line up Quick-MD to print out on your pre-printed patient statements.

> ***Note:*** *Quick-MD also comes with a standard patient statement. It does not print on top of pre-printed forms. If you would like to use the standard statement, check the box labeled* ***"Print Using Standard Patient Statement"*** *under* ***Properties / Miscellaneous Defaults / Other Defaults.*** *You do not need to setup this section of properties if you are using the standard patient statements. (for more information see page 98)*


Set Patient Statement Coordinates
Description Of Data
Line 1
Column1
Line 2
Column 2
1 Date of statement _14 _80 __0 __0
2 Patient account number _12 _80 __0 __0
3 Statement page number __0 __0 __0 __0
4 Patient name _12 __5 __0 __0
5 Patient address 1 _14 __5 __0 __0
6 Patient address 2 _16 __5 __0 __0
7 Patient City,State,Zip _18 __5 __0 __0
8 Regarding Patient Name __0 __0 __0 __0
9 Date of entry _22 __2 __0 __0
10 Description of entry _22 _29 __0 __0
Page Up
Page Down
Print Grid
Save

Step One: Print a Test Form

Load your printer with your pre-printed patient statements and then click **<Print Grid>.** This will print the test grid out on your Patient Statements. *(for more information on using the Test Grid see page 86)*

Step Two: Plug in your Coordinates
You will now decide which fields print on your forms. For each field that you want to print, plug in the appropriate line and column numbers from your test form. If you need a field to print in two places, then you would specify the second coordinates as well. Use the **<PAGE UP> <PAGE DOWN>** buttons to view the rest of the list.

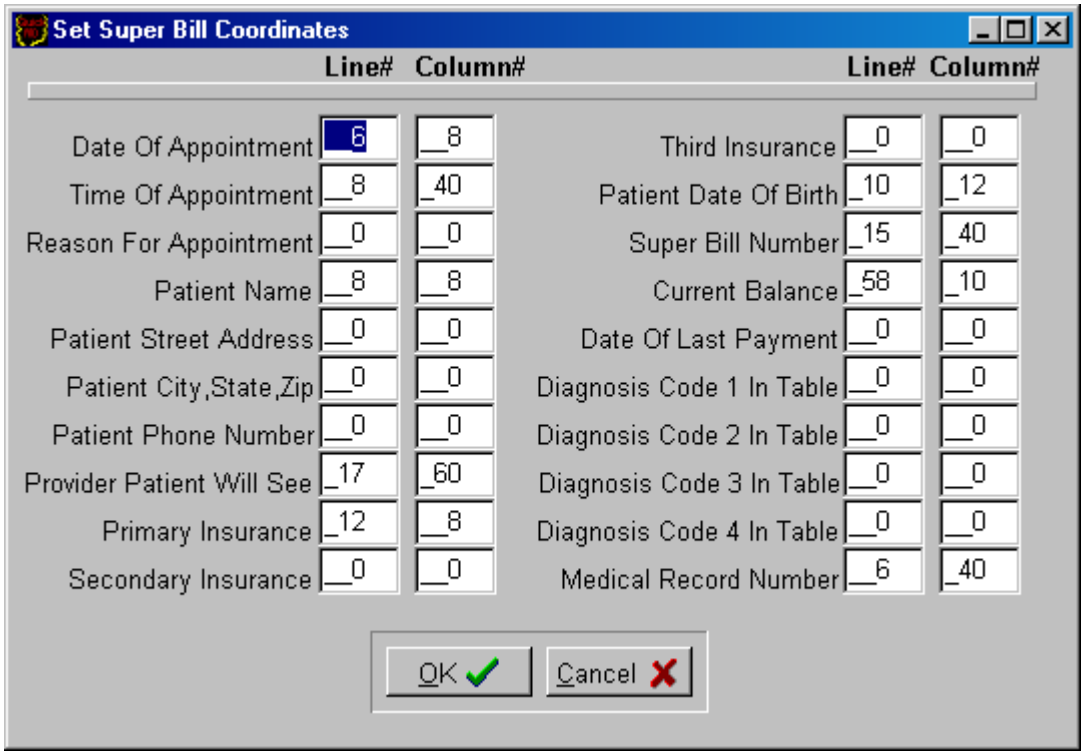
> ***NOTE:*** *Entering 0 in both the line and column fields will prevent that field from printing on your forms.*

A Special Note on line 40:
Line 40 tells Quick-MD where the Statement detail portion of your form is located. This particular field works differently in that the **LINE1, COLUMN1, LINE2** and **COLUMN2** fields function differently here.

> **LINE 1** – Defines the total number of lines on your Patient Statement. A full size 8.5 x11 will have 62 lines. Use your Test Grid to determine the number of lines on your form.
>
> **COLUMN 1** - Defines the Line number of the First Entry in your Statement Detail (date/reference number/description/charges/credits/running balance/balance forward) portion of your form. This section is the body of most patient statements. You define where the first line of that body is located.
>
> **LINE 2** – Defines the Maximum Entries that your charge/payment detail will allow. In other words, how many lines from the First line in the Statement Detail section to the last line, before it starts page two.
>
> > ***Note****: Normally speaking, the global messages are plotted below your current, 30 ,60, 90. balance due line and the statement messages are plotted directly above the current, 30, 60, 90 day line. So be sure to take this into consideration when defining to the system the maximum number of entries above. The number inserted above in Line 2, should stop above the lines the Statement Messages are plotted on, so they will not overwrite each other!*

IMPORTANT: *If the left margin is off or information on your form needs to be shifted downward, these adjustments are made in* ***PRINTER SETTINGS.*** *You will also set your font sizes here.* *(for more information see page 85).*

SUPER BILL SETTINGS
For the standard scheduler only! If you are using the **ENHANCED SCHEDULER** or the **MULTI-VIEW SCHEDULER** these coordinates are entered in the settings of that application. *(For more information see page 115)*


Set Super Bill Coordinates
Line# Column# Line# Column#
Date Of Appointment 6 8
Time Of Appointment 8 40
Reason For Appointment 0 0
Patient Name 8 8
Patient Street Address 0 0
Patient City,State,Zip 0 0
Patient Phone Number 0 0
Provider Patient Will See 17 60
Primary Insurance 12 8
Secondary Insurance 0 0
Third Insurance 0 0
Patient Date Of Birth 10 12
Super Bill Number 15 40
Current Balance 58 10
Date Of Last Payment 0 0
Diagnosis Code 1 In Table 0 0
Diagnosis Code 2 In Table 0 0
Diagnosis Code 3 In Table 0 0
Diagnosis Code 4 In Table 0 0
Medical Record Number 6 40
OK
Cancel

Step One: Print a Test Form
If you are not using the **Q-Scheduler** or the **Multi-View Scheduler**, you may print a test grid from within 1500 settings. To learn how to print a test grid from the **Q-Scheduler** *(for more information see page 115 if you are using Q-Scheduler or page 129 if you are using the Multi-View Scheduler)*

Step Two: Plug in your Coordinates

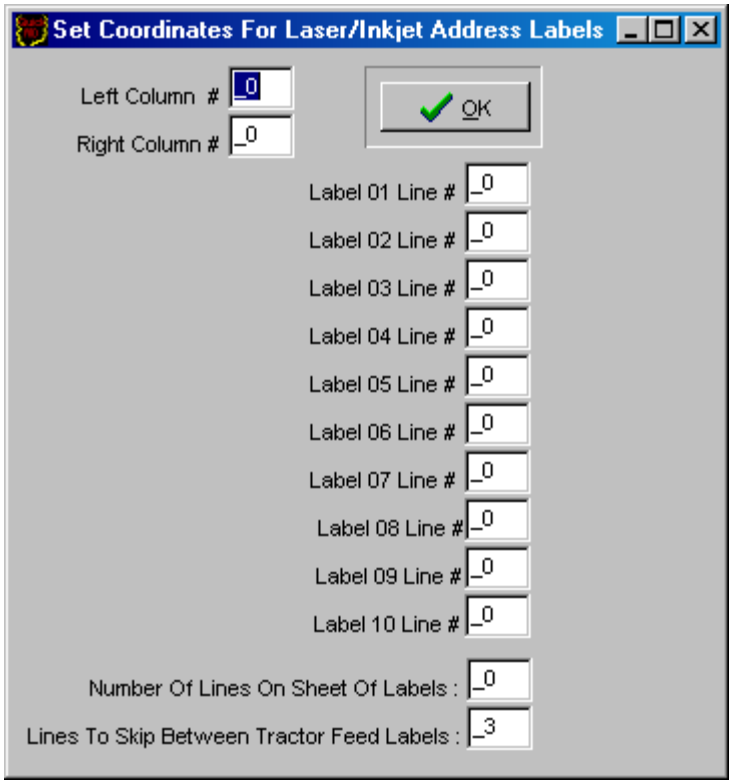
You will now decide which fields print on your forms. For each field that you want to print, plug in the appropriate line and column numbers from your test grid.

> ***IMPORTANT:*** *If the left margin is off or information on your form needs to be shifted downward, these adjustments are made in* ***PRINTER SETTINGS.*** *You will also set your font sizes here. (for more information see page 85).*

LASER/INKJET ADDRESS LABEL SETTINGS

Use 1 inch x 4 inch double column labels.
In order to line up your labels you will need to print a test grid that you can use to plot the coordinates. To print a test grid, go to the Patients Statement Coordinates *(in* ***Properties/Printed Forms/Patient Statement settings/ Print Grid****). (for more information see page 87)*

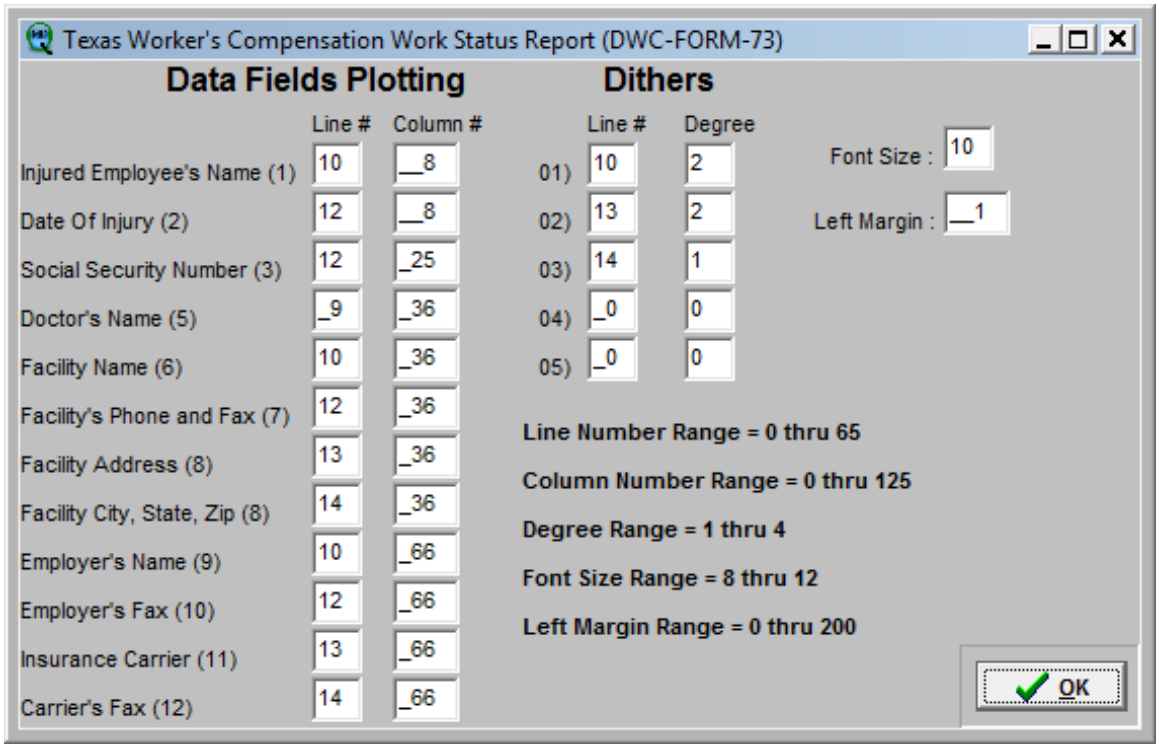
Once you have printed out the grid, lay it over your labels and then plot the coordinates.


Set Coordinates For Laser/Inkjet Address Labels
Left Column #
Right Column #
OK
Label 01 Line #
Label 02 Line #
Label 03 Line #
Label 04 Line #
Label 05 Line #
Label 06 Line #
Label 07 Line #
Label 08 Line #
Label 09 Line #
Label 10 Line #
Number Of Lines On Sheet Of Labels :
Lines To Skip Between Tractor Feed Labels :

Other Form Setup

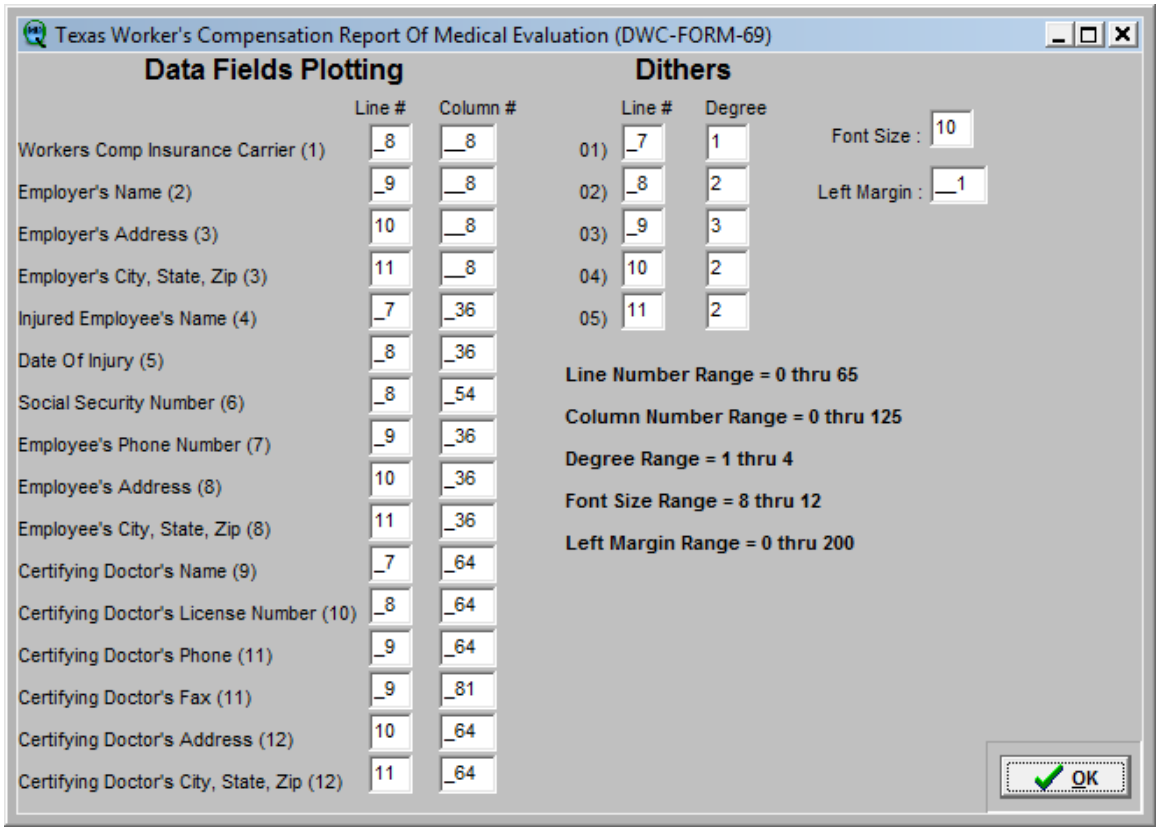
The Other Form Setup allows you to configure your print to generate the workers Compensation forms DWC-69 and DWC-73. You will first need to download the pdf version of these forms from the DWC website. Quick-MD can fill out part 1 (General Information) of the preprinted form.

Texas Worker's Compensation Work Status Report



The concept for lining up this form is the same as lining up your 1500 or patient statement forms. You may want to review this information before proceeding. First you generate a grid on top of the DWC73 form. Next, you adjust your dithers until the rows fall correctly in part 1 of the form. If changes have been made to the dithers then you will need to generate a new grid. Once the dithers are in place, type in the correct row and column for each data filed.

Texas Worker's Compensation Medical Evaluation Report

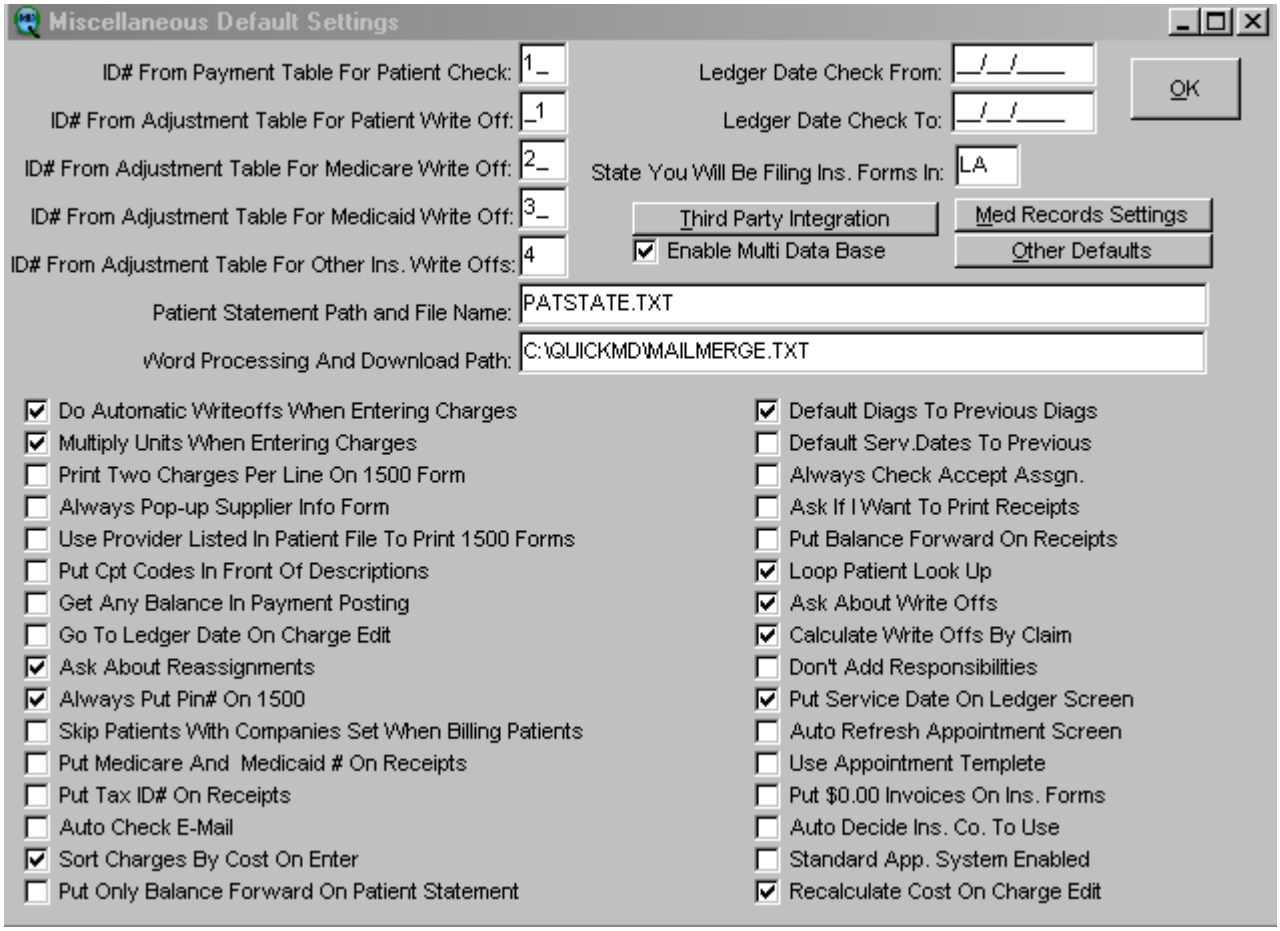

Texas Worker's Compensation Report Of Medical Evaluation (DWC-FORM-69)
Data Fields Plotting
Line #
Column #
Workers Comp Insurance Carrier (1) _8 __8
Employer's Name (2) _9 __8
Employer's Address (3) 10 __8
Employer's City, State, Zip (3) 11 __8
Injured Employee's Name (4) _7 _36
Date Of Injury (5) _8 _36
Social Security Number (6) _8 _54
Employee's Phone Number (7) _9 _36
Employee's Address (8) 10 _36
Employee's City, State, Zip (8) 11 _36
Certifying Doctor's Name (9) _7 _64
Certifying Doctor's License Number (10) _8 _64
Certifying Doctor's Phone (11) _9 _64
Certifying Doctor's Fax (11) _9 _81
Certifying Doctor's Address (12) 10 _64
Certifying Doctor's City, State, Zip (12) 11 _64
Dithers
Line #
Degree
01) _7 1
02) _8 2
03) _9 3
04) 10 2
05) 11 2
Font Size : 10
Left Margin : __1
Line Number Range = 0 thru 65
Column Number Range = 0 thru 125
Degree Range = 1 thru 4
Font Size Range = 8 thru 12
Left Margin Range = 0 thru 200
OK

The concept for lining up this form is the same as lining up your 1500 or patient statement forms. You may want to review this information before proceeding. First you generate a grid on top of the DWC69 form. Next, you adjust your dithers until the rows fall correctly in part 1 of the form. If changes have been made to the dithers then you will need to generate a new grid. Once the dithers are in place, type in the correct row and column for each data filed.

Options

Miscellaneous Defaults

Use this feature to define all Miscellaneous Settings that will be used throughout Quick-MD. The majority of these settings are designed to allow ease of use when enter data and performing functions throughout Quick-MD. Quick-MD can be configured to your way of doing business. Unlike the startup files, these settings can be modified at any time during use of Quick-MD and the changes will be reflected on the client's computer that made the changes.


Miscellaneous Default Settings
ID# From Payment Table For Patient Check: 1
ID# From Adjustment Table For Patient Write Off: 1
ID# From Adjustment Table For Medicare Write Off: 2
ID# From Adjustment Table For Medicaid Write Off: 3
ID# From Adjustment Table For Other Ins. Write Offs: 4
Ledger Date Check From: __/__/____
Ledger Date Check To: __/__/____
State You Will Be Filing Ins. Forms In: LA
OK
Third Party Integration
Enable Multi Data Base
Med Records Settings
Other Defaults
Patient Statement Path and File Name: PATSTATE.TXT
Word Processing And Download Path: C:\QUICKMD\MAILMERGE.TXT
Do Automatic Writeoffs When Entering Charges
Multiply Units When Entering Charges
Print Two Charges Per Line On 1500 Form
Always Pop-up Supplier Info Form
Use Provider Listed In Patient File To Print 1500 Forms
Put Cpt Codes In Front Of Descriptions
Get Any Balance In Payment Posting
Go To Ledger Date On Charge Edit
Ask About Reassignments
Always Put Pin# On 1500
Skip Patients With Companies Set When Billing Patients
Put Medicare And Medicaid # On Receipts
Put Tax ID# On Receipts
Auto Check E-Mail
Sort Charges By Cost On Enter
Put Only Balance Forward On Patient Statement
Default Diags To Previous Diags
Default Serv.Dates To Previous
Always Check Accept Assgn.
Ask If I Want To Print Receipts
Put Balance Forward On Receipts
Loop Patient Look Up
Ask About Write Offs
Calculate Write Offs By Claim
Don't Add Responsibilities
Put Service Date On Ledger Screen
Auto Refresh Appointment Screen
Use Appointment Templete
Put $0.00 Invoices On Ins. Forms
Auto Decide Ins. Co. To Use
Standard App. System Enabled
Recalculate Cost On Charge Edit

ID# From Payment Table For Patient Check: Enter the number that corresponds to the payment code set up for patient check payments in the **Payment Table** *(for more information see page 67)*.

> ***Note:** This feature is to enable the **Do Automatic Write offs When Entering Charges to work** (for more information see page 93)*

ID# From Adjustment Table For Patient Write Off: Enter the number that corresponds to the adjustment code assigned for patient write off in the **Adjustment Table** *(for more information see page 68)*. If no adjustment code exists, leave this field blank.

> ***Note:** This feature is to enable the **Do Automatic Write offs When Entering Charges to work** (for more information see page 93)*

ID# From Adjustment Table For Medicare Write Off: Enter the number that corresponds to the adjustment code set up for Medicare write off in the **Adjustment Table** *(for more information see page 68)*. If no adjustment code exists, leave this field blank.

> ***Note:** This feature is to enable the **Do Automatic Write offs When Entering Charges** to work (for more information see page 93)*

ID# From Adjustment Table For Medicaid Write Off: Enter the number that corresponds to the adjustment code set up for Medicaid write off in the **Adjustment Table** *(for more information see page 68*)**.** If no adjustment code exists, leave this field blank.

> ***Note:** This feature is to enable the **Do Automatic Write offs When Entering Charges** to work (for more information see page 93)*

ID# From Adjustment Table For Other Ins. Write Off: Enter the number that corresponds to the adjustment code that you would like Quick-MD to default to for other insurance write offs in the **Adjustment Table** *(for more information see page 68)*. If no adjustment code exists, leave this field blank.

> ***Note:*** *This feature is to enable the **Do Automatic Write offs When Entering Charges** to work (for more information see page 93)*

Ledger Date Check From: This field allows you to define a "date from" parameter that will restrict anyone from making any entries (charges, payments, adjustments or notes) in the ledger with a date prior to this date, without being warned that they are working outside of the specified date range.

Ledger Date Check To: This field allows you to define a "date to" parameter that will restrict anyone from making any entries (charges, payments, adjustments or notes) in the ledger with a date after this date, without being warned that they are working outside of the specified date range.

State You Will Be Filing Ins. Claims In: Enter the state that you file claims in.

Pat. Statement Paths: This field defines the location on the hard drive where Quick-MD will put the patients statements when they are generated electronically.

Word Processing Paths: This field defines the path within your computer that will be used when reports are downloaded to your computer for use within Word, Word Perfect, Excel or Lotus, etc.

Do Automatic Write-offs When Entering Charges:
Click this box on if you want Quick-MD to automatically write off the amount defined in the Medicare Write Off, Medicaid Write Off or the Fee Schedules contained within each CPT record.
These CPT records are maintained in the **Cpt Table** (for more information see page 43).
You must also define to the system the Medicare, Medicaid. BCBS, and Other Insurance Write Off in the adjustment tables. This is done at the top left of the ***Misc. Default*** screen (see above)

> ***Note:*** *For this option to work, the write off fields above must contain the correct data.*

> ***Note:*** *You will also need to define the proper **Payment** and **Adjustment** codes (for more information see pages 67 and 68)*

Multiply Units When Entering Charges: Click this box on if you want Quick-MD to calculate the total charge by multiplying the *Amount of Charge* in the CPT record times the number of units entered when keying charges. The number of units is found in the *Other Charge Information Screen.* This screen is turned on or off in the **Cpt Entry Options** *(for more information see page 80)*.

> ***Note:*** *For this option to work, the Amount of Charge in the CPT record must contain an amount. Quick-MD will not multiply the number of units if the amount is entered directly in the charge screen.*

Print Two Charges Per Line on 1500 Form: Click this box on if you want to print two charges per line on the 1500 form.

Include Amount Paid on 1500 Form: Click this box on if you want Quick-MD to include any insurance or patient payments received on the 1500 Form.

Always Pop-up Supplier Info Form: Click this box on if you want Quick-MD to pop-up the supplier information form when entering charges on a **PATIENT** claim. Normally, users only have this form pop up on insurance claims. However, by clicking this box on, you will get this form to pop up on all claims, including patient claims.

Use Provider Listed In Patient File to Print 1500 Forms: Click this box on if you want Quick-MD to always use the provider listed in the patient file on the 1500 form regardless of the doctor chosen on the charge entry screen.

Example: This option would pull the patients "default" provider from the demographics screen onto the HCFA as opposed to the Provider listed on the claim during charge entry.

Put CPT Codes in Front of Description: Click this box on if you want the CPT code to appear in the description box when entering charges. You would use this feature if you have setup house codes that are different from the CPT Code they define, as Quick-MD pulls in by house code. This way the description field will display the actual CPT Code before the description of it. *(for more information see CPT records on page 43)*

Go Directly To Referring Phy. On Supplier Information Form Open: Click this box on if you want the prompt/cursor to start at the referring physician field on the supplier information form when it opens. By starting at this field, you are skipping all of the information primarily related to Illness or Accident (workers comp/liability info). This feature does not exclude you form entering information in any of these fields. If you want to enter any information in these fields, you can either back tab or use your mouse to get to these fields.

NOTE: Offices who do a limited amount of Workers Comp would want to check this box.

Get Any Balance in Payment Posting: Click this box on to always pull all balances of claims, regardless of the responsibility, in the **Patient/Insurance Payments (by Claim**) quick posting module.

Go To Ledger Date on Charge Edit: Click this box on if you want the prompt to start in the ledger date when editing claim charges. If not, the prompt will begin in the diagnosis field.

Ask About Reassignments: Click this box on if you want to be asked about reassignment of responsible party when posting payments in the patient ledger utilizing the F1-Pay function if the patient has a secondary or third insurance.

Always Put Pin# on 1500: Click this box on if you want the referring physician's UPIN number to appear on all insurance claims.

***Note:** Quick-MD will always put the pin# on government claims, even if this option is not checked.*

Skip Patients With Companies Set When Billing Patients: Click this box on to utilize the occupational medicine/industrial medicine component to generate an invoice to a company instead of individual claims.

Put Medicare and Medicaid # on Receipts: Click this box on if you want the provider's Medicare and Medicaid numbers to appear on patient receipts.

Put Tax ID# on Receipts: Click this box on if you want the provider's tax ID# to appear on patient receipts.

Auto Check E-Mail: Click this box on if you want the system to automatically check your email for you.

Sort Charges By Cost on Enter: Click this box on if you want charges to automatically be sorted in descending order by cost, regardless of which order they were entered.

Put Only Balance Forward On Patient Statement: Click this box on if you only want balance forward to print on the patient statement and not the charges forward and the credits forward.
Default Diags to Previous Diags: Click this box on if, in the **Charge Entry Screen** *(for more information see page 211)* you want the current charge to automatically use the diagnosis from the previous charge line when entering charges on a claim.

Default Serv. Dates to Previous: Click this box on if you want the service date of the line item that you are adding to default to the one entered before it.

Always Check Accept Assign: Click this box on if you want to accept assignment on all insurance claims. Quick-MD will accept assignment on government claims if that box is checked in **Properties**/**Patients/Patient Defaults**, even if this option is not checked.

Ask If I Want to Print Receipts: Click this box on if you want to have the window pop-up that asks if you want to print a receipt after a patient payment is recorded in the charge screen.

Put Balance Forward On Receipts: Click this box on if you want the balance forward to print on the patient's receipt.

Loop Patient Look Up: Click this box on if you want to have Quick-MD prompt you to look up another patient when performing the patient look up function. Once you choose save within a patient file, Quick-MD will then prompt you to look for another patient if this feature is turned on.

Ask About Write Offs: Click this box on if you want to be prompted about writing off the claim balance when entering payments in the patient ledger utilizing the F1-Pay function.

Calculate Write Offs By Claim: Click this box on if you want to calculate write offs by claim and not by line item.

Don't Add Responsibilities: Click this box on if you want to replace the existing responsibility code in lieu of adding the additional responsibility to that field when reassigning a claim.

Put Service Date on Ledger Screen: Click this box on if you want the "date of service" to appear in the comment field on the patients ledger screen.

Auto Refresh Appointment Screen: (STANDARD SCHEDULER ONLY) Click this box on if you want to auto refresh each user's screen in a network environment. This will update the screen every 15 seconds for any changes made to the schedule by another user.

Use Appointment Template: (STANDARD SCHEDULER ONLY) Click this box on if to utilize the appointment template feature in the appointment schedule. This feature allows templates to be saved and copied in future periods.

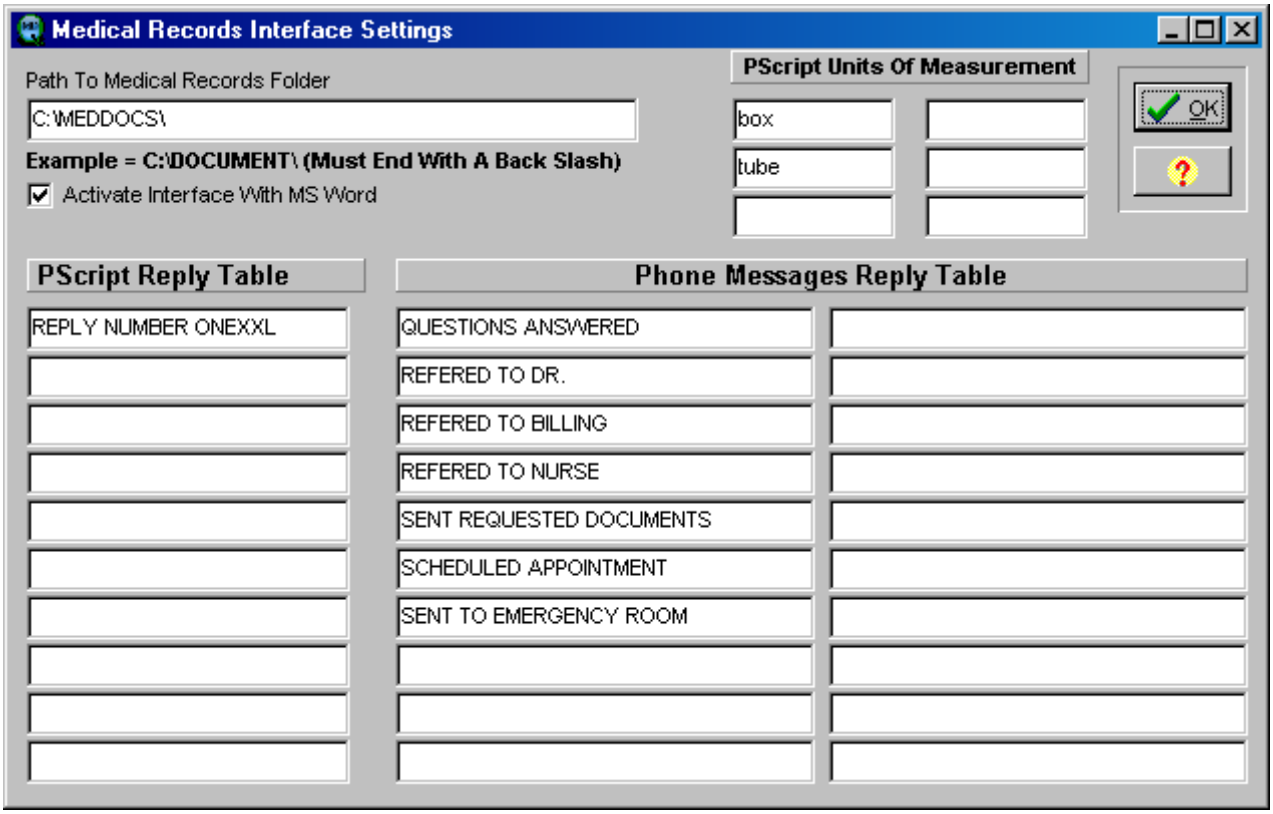
Put $0.00 Invoices on Ins. Forms: Click this box on if you want to put charge items priced at $0.00 on the insurance form when billing.

Auto Decide Ins. Co. to Use: Click this box on if you want Quick-MD to automatically decide which one of up to four primary and/or up to 4 secondary insurances assigned to this patient should be used based on the date of service of the claim.

Recalculate Cost on Charge Edit: Click this box on if you want Quick-MD to automatically recalculate the cost of the CPT Code when you edit the charge by hitting F4 in the ledger.

MEDICAL RECORDS SETTINGS:
Use this feature to setup your medical records Interface.

NOTE: In order to use the Electronic Medical Records Interface, each user will have to have Word 97 or later installed on their local hard drive.



PATH TO MEDICAL RECORDS FOLDER – Set the path to your computer where you will store all your Medical Documents.

NOTE: *You will also want to set your default directory in MS Word. Go to* ***Tools/Options/File locations*** *and define to Word where these documents will be stored.*

ACTIVATE INTERFACE WITH MS WORD – Click this check box to Activate the Medical Records Interface with MS Word.

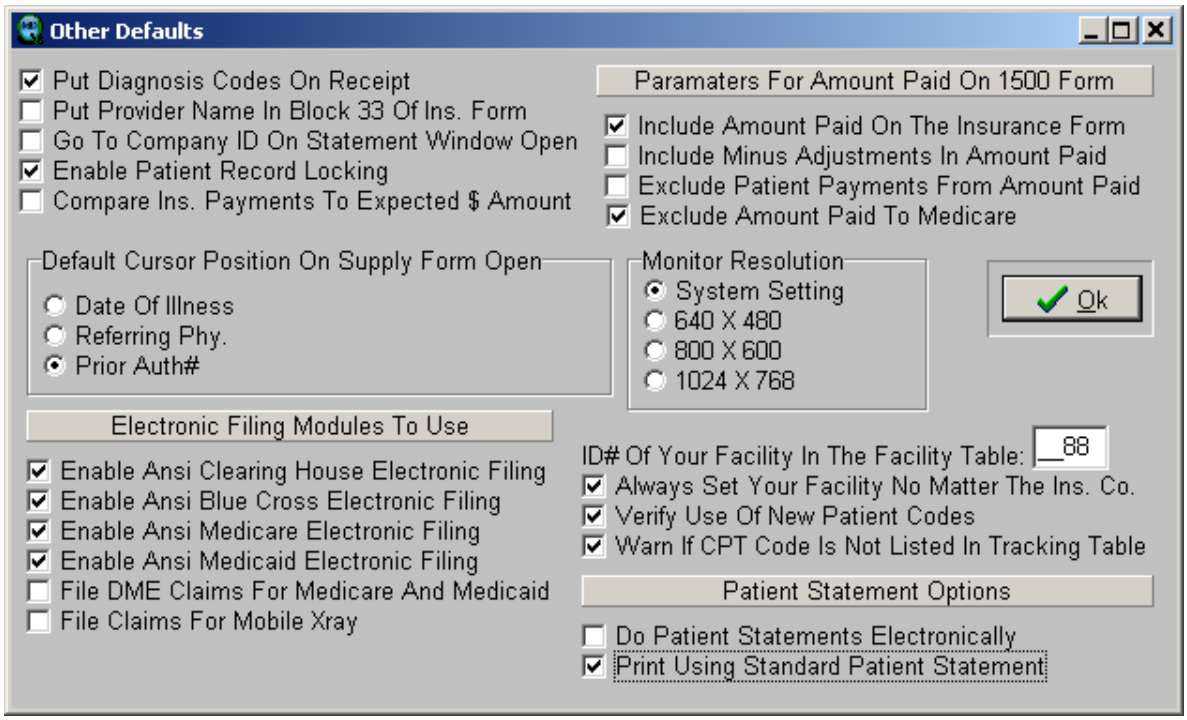
NOTE: *Also you will need to go to* ***System Utilities/Set Operator Rights*** *and be sure each operator has the rights to use the Electronic Medical Records and its various features.*

PRESCRIPTION REPLY TABLE – Use this feature to define up to 10 of the most common replies your practice uses when answering patient calls regarding prescriptions.

PHONE MESSAGES REPLY TABLE – Use this feature to define up to 20 of the most common replies your practice uses when answering patient calls.

Prescription Units Of Measurement – Use this feature to define up to 6 units of measurement that can be use when creating a prescription. If billing drugs electronically then you will need to add the following units: IU (International Units), UN (Units), Mill (Milliliter) and Gram (Gram). *(for more information see page 208)*

OTHER DEFAULTS:


Other Defaults
Put Diagnosis Codes On Receipt
Put Provider Name In Block 33 Of Ins. Form
Go To Company ID On Statement Window Open
Enable Patient Record Locking
Compare Ins. Payments To Expected $ Amount
Paramaters For Amount Paid On 1500 Form
Include Amount Paid On The Insurance Form
Include Minus Adjustments In Amount Paid
Exclude Patient Payments From Amount Paid
Exclude Amount Paid To Medicare
Default Cursor Position On Supply Form Open
Date Of Illness
Referring Phy.
Prior Auth#
Monitor Resolution
System Setting
640 X 480
800 X 600
1024 X 768
Ok
Electronic Filing Modules To Use
Enable Ansi Clearing House Electronic Filing
Enable Ansi Blue Cross Electronic Filing
Enable Ansi Medicare Electronic Filing
Enable Ansi Medicaid Electronic Filing
File DME Claims For Medicare And Medicaid
File Claims For Mobile Xray
ID# Of Your Facility In The Facility Table: 88
Always Set Your Facility No Matter The Ins. Co.
Verify Use Of New Patient Codes
Warn If CPT Code Is Not Listed In Tracking Table
Patient Statement Options
Do Patient Statements Electronically
Print Using Standard Patient Statement

PUT DIAGNOSIS CODE ON RECEIPT – Use this feature to put the diagnosis codes on your patient receipts.

PUT PROVIDER NAME IN BLOCK 33 OF INSURANCE FORM – If you bill as a clinic and your specialty requires you to also put the provider name in block 33, check this box.

GO TO COMPANY ID ON STATEMENT WINDOW OPEN – Use this feature to change the cursor default from Patient Name to Insurance/Company ID # field.

ENABLE PATIENT RECORD LOCKING – Use this feature to enable record locking on Quick-MD. (Consult your local Quick-MD representative before enabling this feature!)

COMPARE INS. PAYMENTS TO EXPECTED AMOUNT – Use this feature have Quick-MD warn you when you are receiving a payment that is different from the expected amount listed in the fee schedule.

DEFAULT CURSOR POSITION ON SUPPLY FORM OPEN – This setting lets you configure the position that your cursor will land in the supply form is opened. *(for more information see page 170)*

ELECTRONIC FILING MODULES TO USE - Use this feature to tell Quick-MD which billing modules to use. If the ANSI sections are disabled, then you will only be able to access the NSF billing portion of Quick-MD.

PARAMETERS FOR AMOUNT PAID ON 1500 FORM - Use this feature to configure what information Quick-MD will print in the payment field of the 1500 form.

MONITOR RESOLUTION – Use this feature to set up the monitor resolution that you want Quick-MD to run at. If you do not want Quick-MD to change your monitor settings then you will need to choose the **System Setting** option.

ID# OF YOUR FACILITY IN THE FACILITY TABLE – Use this feature to set the facility that Quick-MD should default to when entering Medicare, Rail Road Medicare and Champus Claims. This facility ID will go in the location for the facility where services where rendered on the 1500 form. *(for more information see page 170)*

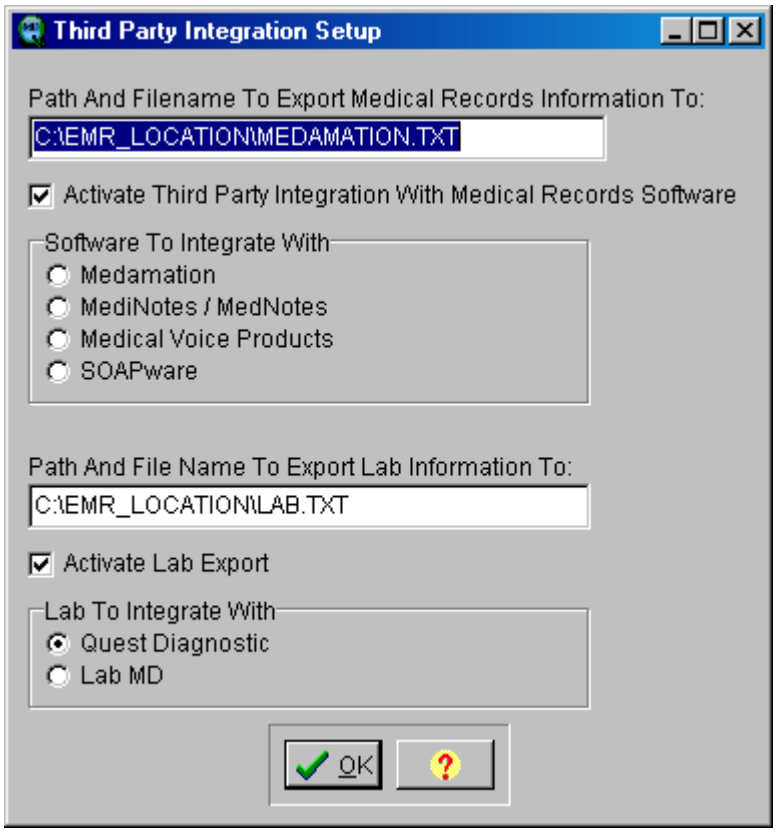
Always Set you facility no matter the insurance company – Use the feature if you always want your facility as the facility where service where rendered, regardless of the insurance company that is being billed.
Verify use of new patient codes – Use this feature if you want the system to warn you when you are entering new patient CPT codes on existing patients.

Note: *Quick-MD considers CPT codes 99201 through 99205 and 99242 through 99245 as new patient CPTs*

Patient Statement Options – Set the default behavior for patient statements. *(for more information see page 216)*

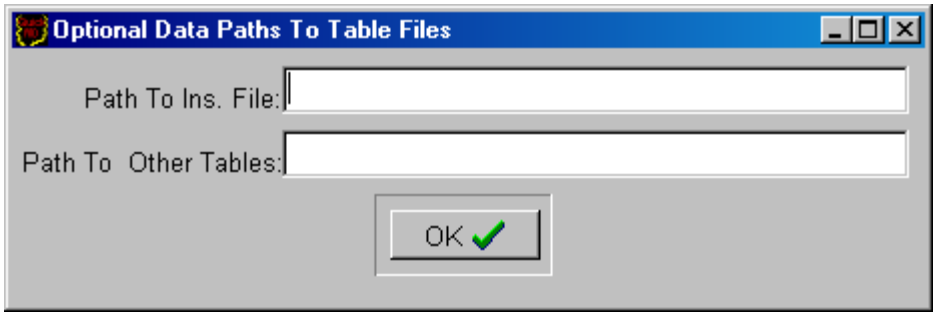
> ***Note:*** *If print using standard patient statement is check then Quick-MD will print the complete patient statement. Otherwise, it will print on a pre-printed form.*

Third party information:



Quick-MD can export patient demographics to a number of different EMR and Lab systems. To be able to use this feature you will need to type the location where you want the export file located. Next, you will check the button labeled **Active Third Party Integration** or **Activate Lab Export.** Choose the EMR system that you will integrate with, and click **OK**.

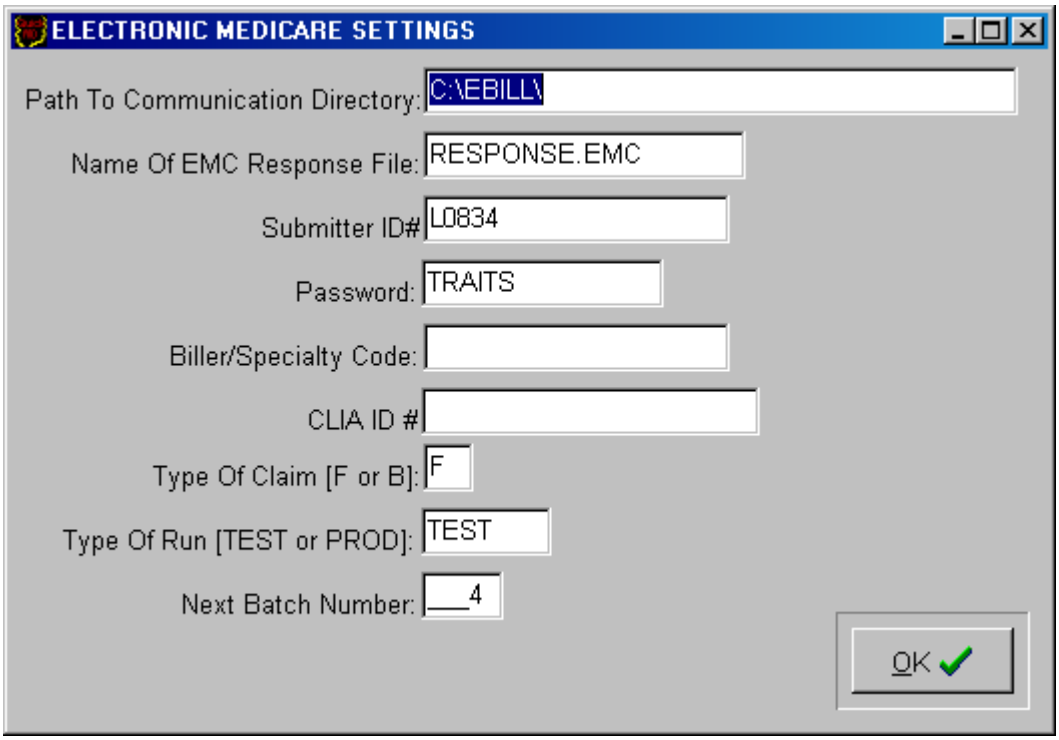
Table Data Paths

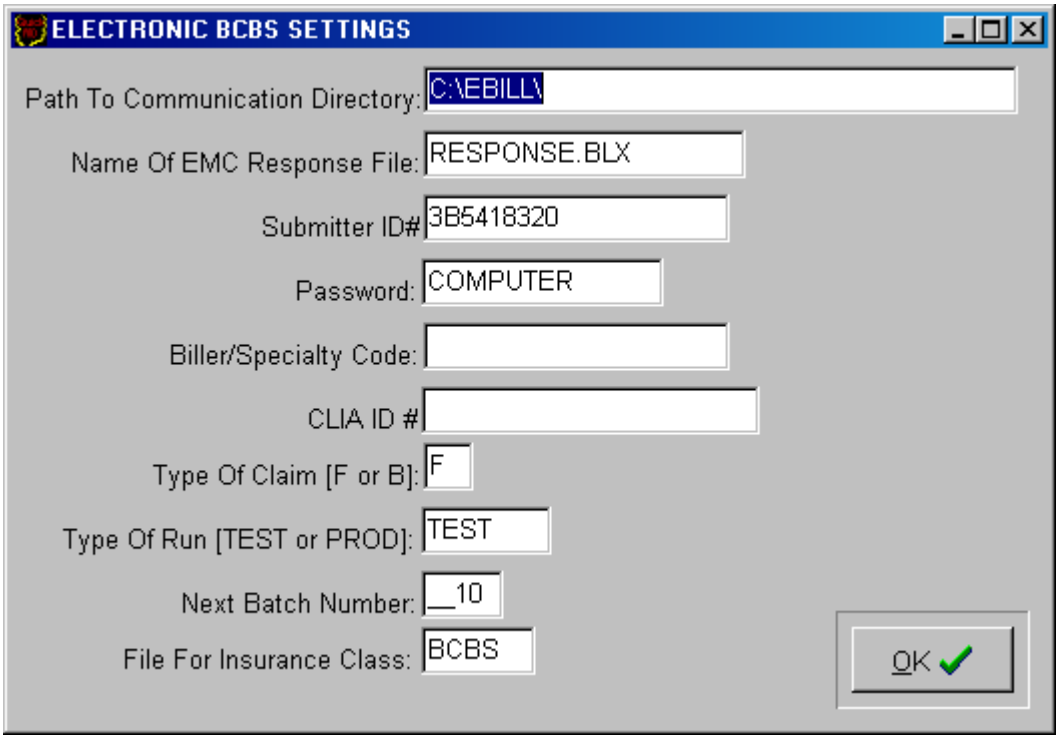


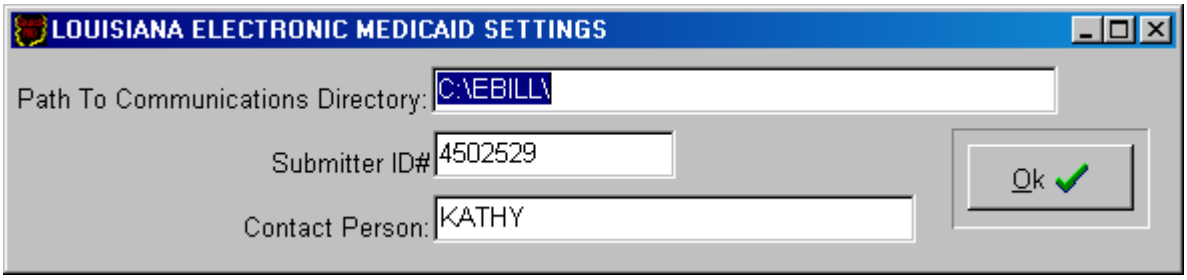
This feature allows you to select optional data paths to table files. This option is rarely used but would be utilized if tables were used that were not located within the Quick-MD directories.

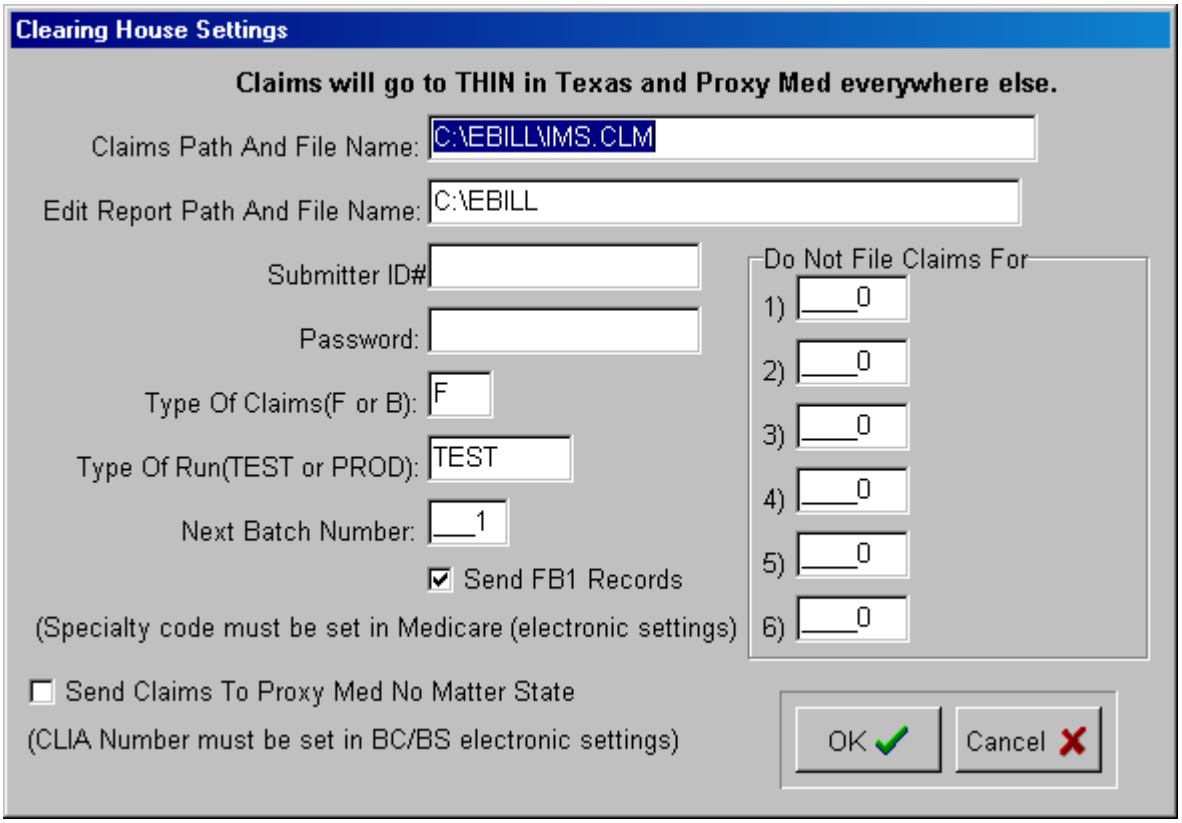
Electronic Filing

Electronic Medicare, Medicaid, Blue Cross and Clearing House Settings




ELECTRONIC BCBS SETTINGS
Path To Communication Directory:
C:\EBILL\
Name Of EMC Response File:
RESPONSE.BLX
Submitter ID#
3B5418320
Password:
COMPUTER
Biller/Specialty Code:
CLIA ID #
Type Of Claim [F or B]:
F
Type Of Run [TEST or PROD]:
TEST
Next Batch Number:
__10
File For Insurance Class:
BCBS
OK


LOUISIANA ELECTRONIC MEDICAID SETTINGS
Path To Communications Directory:
C:\EBILL\
Submitter ID#
4502529
Contact Person:
KATHY
Ok


Clearing House Settings
Claims will go to THIN in Texas and Proxy Med everywhere else.
Claims Path And File Name: C:\EBILL\IMS.CLM
Edit Report Path And File Name: C:\EBILL
Submitter ID#:
Password:
Type Of Claims(F or B): F
Type Of Run(TEST or PROD): TEST
Next Batch Number: 1
Send FB1 Records
(Specialty code must be set in Medicare (electronic settings)
Do Not File Claims For
1) 0
2) 0
3) 0
4) 0
5) 0
6) 0
Send Claims To Proxy Med No Matter State
(CLIA Number must be set in BC/BS electronic settings)
OK
Cancel

The Electronic Settings contains the data needed for electronic claim submissions. This information will be accumulated through applications and correspondence with the intermediary/company you submit your Medicare, Medicaid, Blue Cross, or clearinghouse claims to.

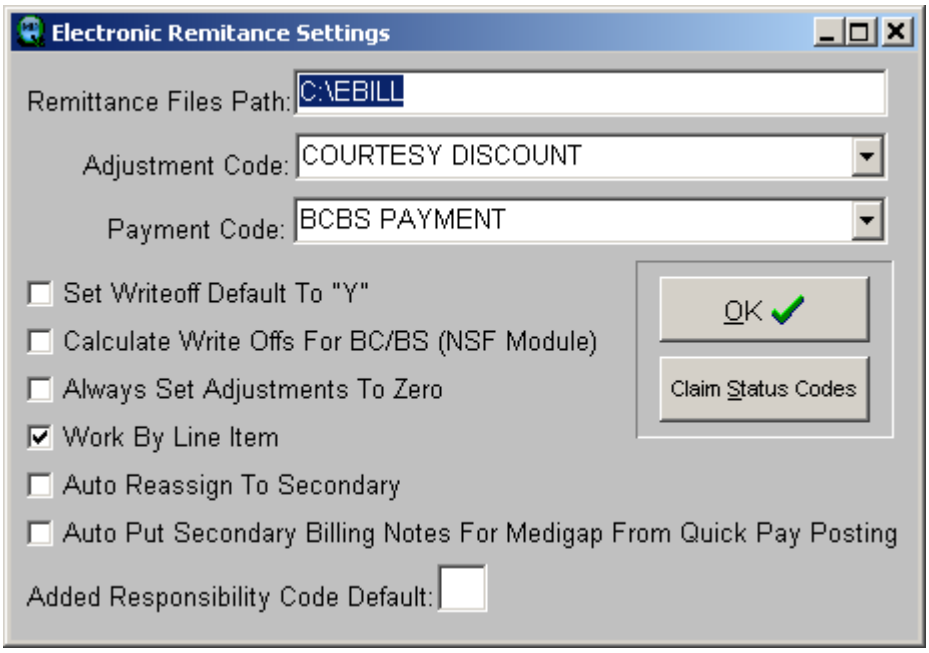
You will define to the system where your live runs will be located on the hard drive and the file name, if applicable. You will also tell the system where to retrieve the downloaded reports.

Note: Here at Quick-MD, we like to set up a directory on the root directory, called Ebill, to hold all of these files. If the field asks for a file name, then this name is issued by the payer, and will be defined by the user. If it does not, then the file name is hard coded into the system.

Note: *When sending claims as a test, the "Type Of Run" should read TEST for testing. When notified that claims have passed the test, then "Type Of Run" should read PROD for production. When set in the Test mode, the system will not ask to put the billing notes. Also, please note that when filing to the clearinghouse, you may tell the system to exclude up to 5 companies.*

Note: *If you are sending claims to Gateway EDI then your Claims Path and File Name will be C:\ebill\claims.txt*

Electronic Remittance Settings



This Electronic Medicare Remittance Settings contains the data needed for electronic remittance advice from Medicare.

Remittance File Path: This is the path on your computer where your remittance files are stored.

Adjustment Code: Enter the code from the **Adjustment Table** *(for more information see page 68)* for Medicare adjustments.

Payment Code: Enter the code from the **Payment Table** *(for more information see page 67)* for Medicare payments.

Set Write-off Default to "Y": Turning this option on will default the write off field in the payment posting module to Y when processing Medicare Electronic Remittances.

Calculate Write Offs For BC/BS (NSF Module): Check this box if you want the system to automatically calculate the Blue Cross / Blue Shield write offs when posting a NSF ERA.

Added Responsibility Code Default: Turning this option on will default the added responsibility on the payment posting field to the code defined here.

Always Set Adjustments To Zero: Always set the adjustment amount to zero regardless of the other settings.

Auto Reassign To Secondary: Check this box if you want the system to automatically reassign a claim to the secondary insurance company when posting electronic remittance files.

Auto put Secondary Billing Notes For Medigap From Quick Pay Posting: Check this box if you want the system to automatically put a secondary billing note into your ledger, for medigap insurance companies, when posting electronic remittance files. You can tell the system that a certain company is a medigap company by checking the box labeled "This is a Medigap Company" on the insurance information screen.

Claims Status Codes: This button allows you to set up the claims status codes with descriptions that are sent with the electronic remittance advice.

SCHEDULING APPOINTMENTS IN QUICK-MD

Quick-MD comes with three different scheduler's. Our flagship scheduler is called the Q-Schedule. *(for more information see page 105)* It runs as a separate application on your toolbar which gives you access to it at anytime without leaving Quick-MD or any screens that you might be in within Quick-MD. You may also be working in any other application as Quick-MD doesn't have to open to use the scheduler. It is the recommended Scheduler because of its accessibility from outside of the program and its powerful features.

We did leave our original Scheduler in there because in some instances it is the best choice for the job. Specifically if your practice dictates that you see two separate provider books open at the same time.

Quick-MD also comes with a Multi-View appointment scheduler. It allows you to be able to view more than one provider's book at a time. *(for more information see page 124)*

USING Q-SCHEDULE

Getting there:

The Q-Schedule is a separate, but integrated, application that is started from its own icon. Set an icon to "newaps.exe' in the medical folder. When open, this Scheduler operates on a separate tab on the tool bar, which allows for access to it while working anywhere in Quick-MD or any other program.

SETTING UP

In the upper left hand corner, all providers that have been set up in the scheduler are shown. Providers are added to the scheduler by accessing the **SETTINGS** *(for more information see page 114)* button and then the "**SET PROVIDER NAMES**" button. Both first name and last name must be set.

***NOTE:** Once a new provider has been added, the scheduler must be closed and restarted to have the change take effect.*

USING TEMPLATES

This feature will save a layout of blocked or colored time in the schedule. To create a template, use the appropriate **<F>**unction key to set the colors for your template. **<F>**unction key definitions are found under the **<Help>** button on Q-Schedule's main menu bar. Once you have setup the colors for a particular day, click 

.

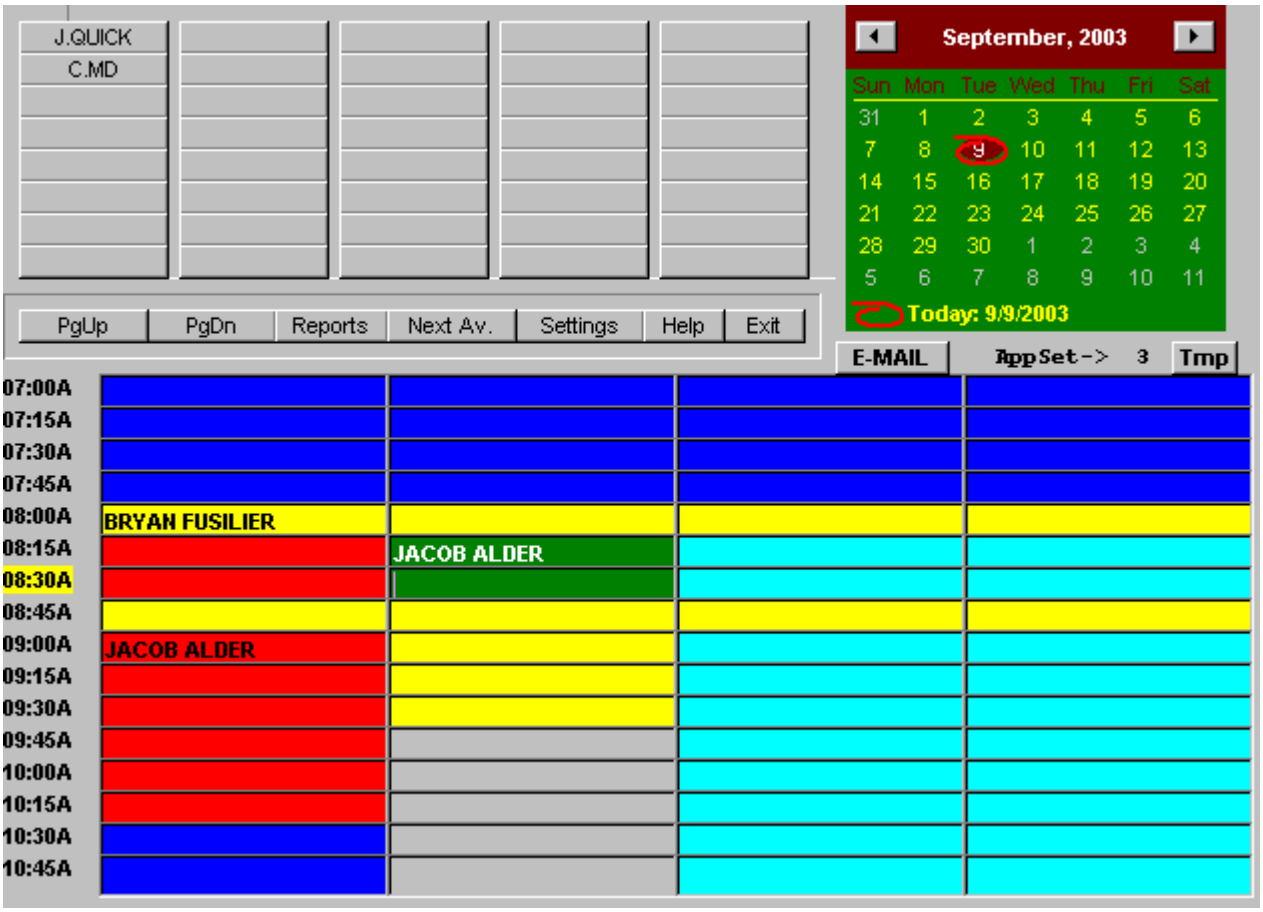
***NOTE:** Templates are configured on a per day of the week basis, ie. Mondays, Tuesdays, etc.. Not individual dates in the Calendar.*

***EXAMPLE** - blocking out lunch from 12:00 PM to 1:00 PM on a Monday, will block out all lunch hours for all future Mondays that don't currently have appointments scheduled on them.*

To use this feature, pick an individual provider, block out times and/or set other colors for that day by using the appropriate <F>unction keys, and click on TMP button next to the bottom right hand corner of the calendar. The templates will be set for each provider, for each day of the week, separately.

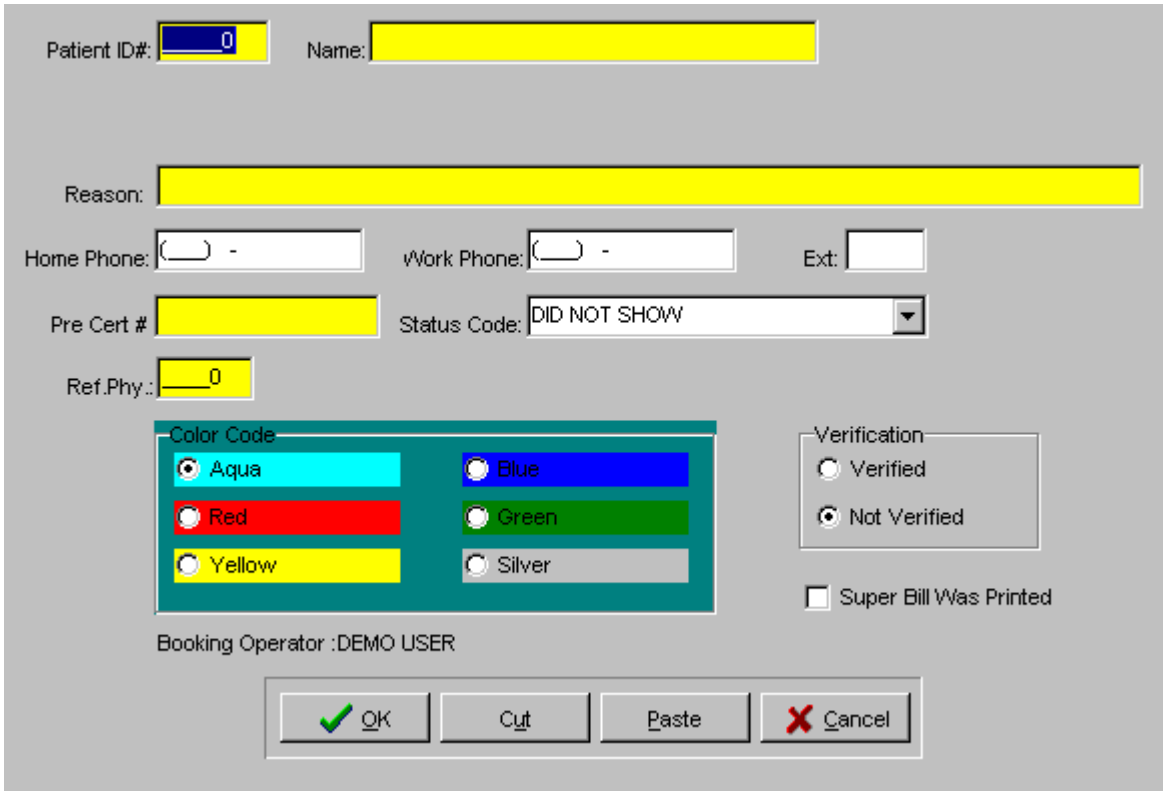
Using The Scheduler

To view a particular provider's schedule, click on that provider's name and their schedule will appear. Across the top of the screen the system will display which provider for what day of the week we currently have open. The calendar is shown at the upper right hand corner. Today's date will always be circled in red. To go to a particular day, click on that day. The right and left arrow keys allow for toggling to previous and future months.



Create an Appointment

Click in the time slot of one of the (up to four) appointment books that you want to schedule an appointment for and select **<F1>** or double click the time slot to create an appointment.



Id# - Enter the patients ID# if you know it or Select **<F1>** to bring up the **Look Up Patient File Screen** where you can search for the patient in your database. *(for more information on using the **Look Up Patient File Screen** see page 211)*

> ***Important**: If you are scheduling an appointment for a patient who is not in your system, then enter through the **ID#** field and simply enter the new patient's name, phone number and the reason for the visit. This allows you to schedule patients without setting them up in the system first. If the patient does not show up for the visit then you have not wasted an Id number, nor lost the time to set them up un-necessarily.*
>
> ***Note:** Also you may want to view this **Patient's Ledger Balances** and **Inter Office Messages** when scheduling, if brought in by ID#. These features are turned on in **Settings** (for more information see page 114).*

Name – Once the patient has been pulled into the scheduler by ID#, this field will be populated with the patient's name. If you are scheduling an appointment for a new patient, one that is not already setup in Quick-MD, you can type the patient's name here.

> ***Note:** If your cursor is in the name field, and the patient has been pulled into Q-Schedule by ID#, you can hit <F1> to verify and even edit the patient's demographics from this field while you are scheduling your appointments.*

Reason - Enter the reason for the visit in the comments field or hitting **<F1>** will open the **Appointment Reason Table** where you have already setup your top 20 Appointment Reason Codes. *(for more information see **Settings** on pg 114)* Type the number of the appointment reason listed and hit **<Enter>**.

Verification - Select the appropriate code when patient is notified of appointment: When verifying appointments, click in the desired time slot and hit the **<F1>** key, to view this patient's information. If you

click on verified, an asterisk (*) will appear on the main screen next to the patient's names that have been verified, making it easy to see who is verified and who isn't.

Ref. Phy. - Enter the **ID#** of the referring physician, if known, or hit **<F1>** to browse the referring physician table. If the referring physician is not in your system, you can simply hit **<F10>** to add them from here.

Pre Cert# - Hit **<F1>** to open Quick-MD's **Managed Care Module** to either setup or select a pre-authorization code for this visit. Double click on the authorization number that applies to this visit and the system will automatically bring over both the referring physician and the authorization number. Or if you know it, simply type in the authorization number. Once set on the booking screen , the authorization number can now print on the superbill, as this is necessary information needed during the charge entry process.

Status Code - Select the appropriate code: To track all patients who either showed up for their appointments or did not show up for their appointments. Click in the desired time slot and hit the ***<F1>*** key to open the appointment details screen where you can now set the query code. This is usually done at the end of the business day, or as an appointment comes due, so that the appropriate selection can be made. This feature is for reporting features only.

> ***Note:*** *Some offices will set up a book called cancellations, and move cancellations to this book to keep the cancelled patient in reporting, making that time slot available for another booking.*

Color Code - choose a color that you would like the shade of that appointment field to be. These appointments can have preset colors and a preset amount of time blocked out. This is done in the S**cheduler Settings**, S**et Appointment Reasons**. The commands are listed there for the setup. *(For more information see page 115)*

Select **<Ok>** and the Patient name will appear in the selected time area.

Moving Appointments

Quick-MD allows user to cut and paste appointments when moving an appointment within the schedule is necessary. To use this feature, click in the desired time slot of the appointment to be moved. Double click or press ***<F1>*** to open the appointment window and click on the <**Cut>** button. Quick-MD will ask you if you want to cut the appointment. Choose yes. Then, go to the provider book, time and day that you want to move the appointment to. Double click or press ***<F1>*** to open the appointment window and click on the **<Paste>** button. Quick-MD will ask you if you want to paste the appointment. Choose **<Yes>**.

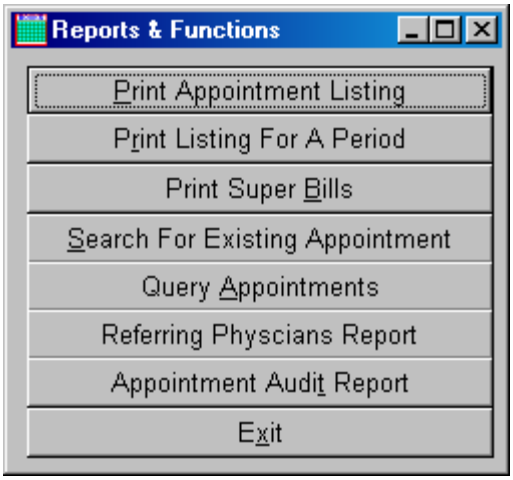
Blocking an Entire Day

You can prevent appointments from being scheduled on a particular day by blocking the entire day. Select the provider you wish to block the day for and then use the Calendar to select the day you wish to block. Put you cursor in any time slot and hit **<F9>.** All time slots will be turned to the color red which signifies blocked time. To unblock the day, put your cursor in any timeslot and hit **<F11>**. This will revert the blocked day back to the original template.

Pg Up/Pg Dn

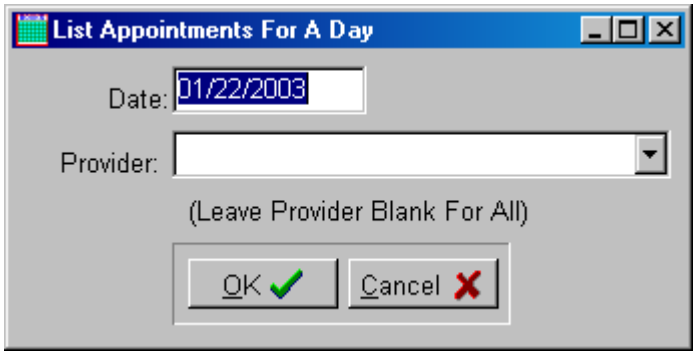
The **<Pg Up>/<Pg Dn>** buttons allow for moving up and down the time slots within each provider's books or you may use a mouse with a scroll wheel.

Reports



Print Appointment Listing

Use this feature to Print Appointment Listings for a day, either for an individual provider, or for all providers if left blank.

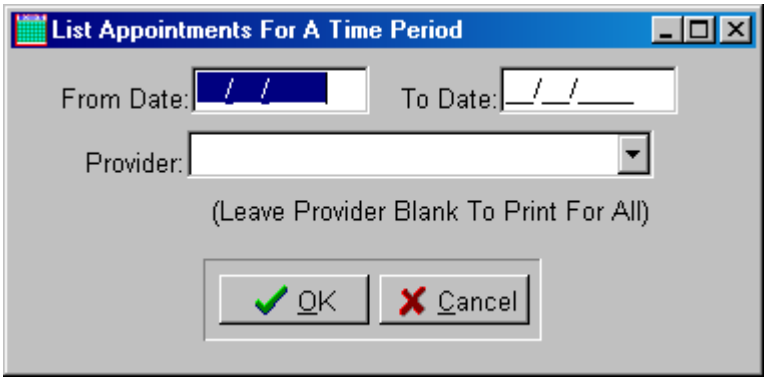


Choose a date and a provider
(Leaving this field blank will print all providers in the scheduler).

***Note:**. There are two different report formats available, Standard or Four Column. (for more information see **Settings** on pg 114).*

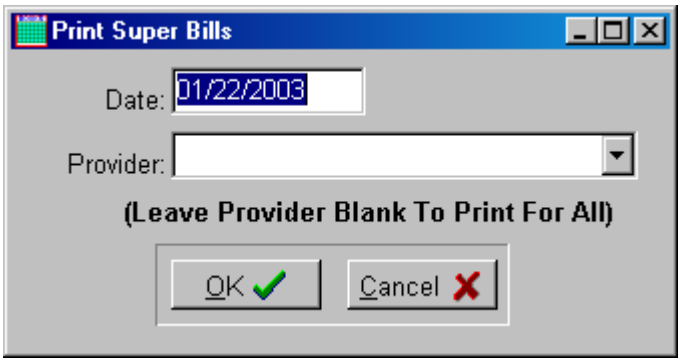
Print Appointment Listing for a date range

Enter the date range and select a provider, or leave blank for all providers.



Print Super Bills

Use this feature to batch Print Super Bills for a specific date.

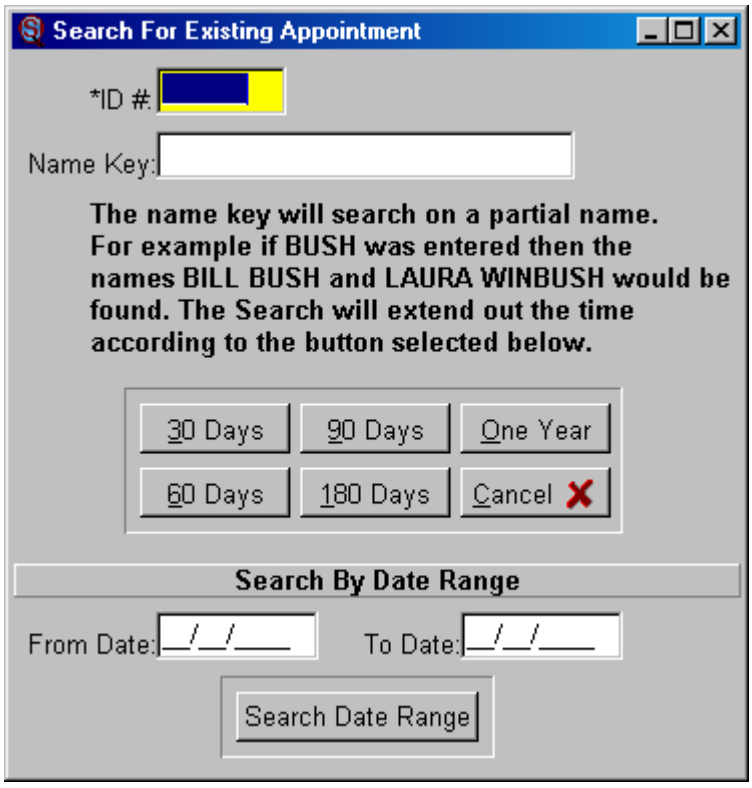


Date - Enter Date for which you want Super Bills printed.

Provider - Enter the Provider for which you want Super Bills printed. (leaving this field blank will print all providers in the scheduler). Or you may print a single super bill by clicking in the desired time slot and hitting the F8 key.

Search For Existing Appointment

Use this feature to search for and view an existing appointment for a patient.


Search For Existing Appointment
*ID #:
Name Key:
The name key will search on a partial name. For example if BUSH was entered then the names BILL BUSH and LAURA WINBUSH would be found. The Search will extend out the time according to the button selected below.
30 Days
90 Days
One Year
60 Days
180 Days
Cancel
Search By Date Range
From Date: __/__/____
To Date: __/__/____
Search Date Range

ID - use the **<F1>** key to browse your Patient Tables, highlight the patient you want, then hit the enter key to start your search, or if the patient is not in your patient files, you may search for his/her appointment by Name. The name search will search on a partial spelling of the name.

Note: *The system will search much quicker by ID# than a name or partial key.*

30 days – Click this button to only search out 30 days from today's date. Makes searching much Quicker.

60 Days - Click this button to only search out 60 days from today's date. Makes searching much Quicker.

90 Days - Click this button to only search out 90 days from today's date. Makes searching much Quicker.

180 Days - Click this button to only search out 180 days from today's date. Makes searching much Quicker.

1 Year - Click this button to only search out 1 Year from today's date. Makes searching much Quicker.

To search by a date range:

Beginning Date - enter the date you want Quick-MD begin search. Quick-MD defaults to today's date as a beginning date for the search.

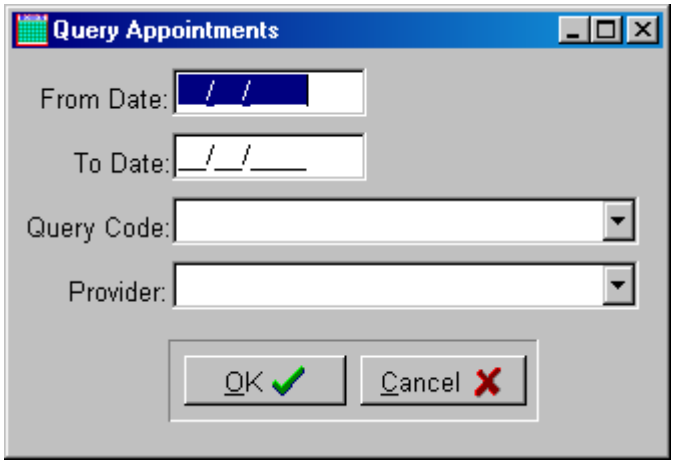
Ending Date - enter the date you want Quick-MD to end search.

Select **<Search Date Range>** to display all appointments set for this patient.

Query Appointments

Use this feature to run reports based your on the status codes of your scheduled appointments.

***Example:** I want to run a report of all patients who **Did Not Show** within a date range.*



From Date - select the date you want to begin your report.

To Date - select the date you want to end your report.

Query Code - select the appropriate Status code.

Provider - select the appropriate provider.

Select **<Ok>**

Data Output Processor - will display all patients with the selected date of appointments and the selected Query Code.

Select **Print All** to print the report or Select **Close** to exit

Next Av.

Use this feature to search for the next available appointment.



Start Search as of What Date - pick date to start search

Start Search as of What Time - use the **down arrow key** to display the earliest time you can make an appointment

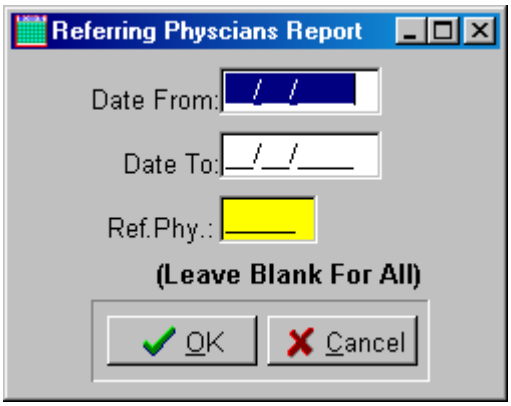
Latest Time Acceptable - use the **down arrow key** to display the latest time an appointment can be made

Select **<Ok>** to display Appointment Schedule

Note: *The system is looking for the first time slot that has nothing booked in it or is Not blocked with the red color. So in order to use this function, all non-available times have to be blocked in red.(i.e.-must block out all lunch hours.)*

Referring Physician Report

Use this feature to run a report on referring physicians and the patients they referred to you by a date range. The referring physician has to be set in the scheduler for this report to work. This report may be run for an individual Provider, or leave blank for all. Quick-MD will run the report listing the Providers alphabetically with the patients they referred under their name.



Appointment Audit Report

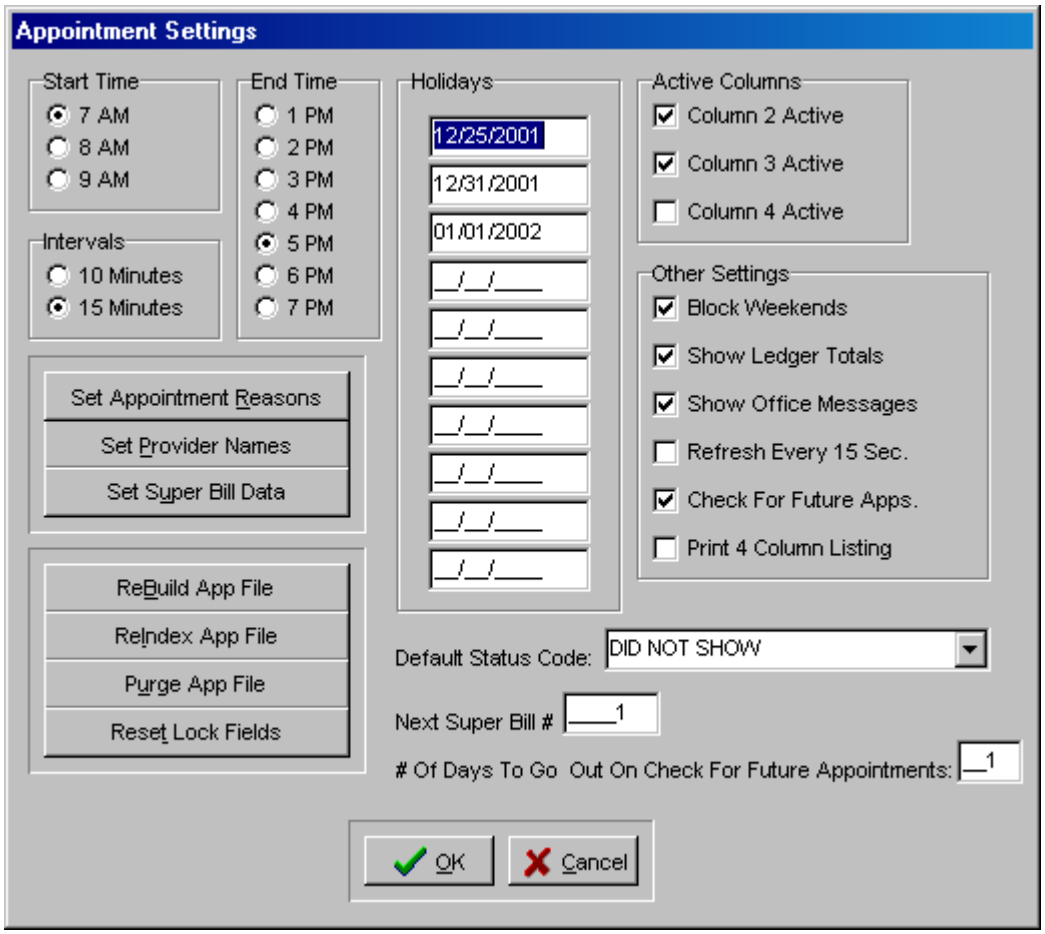
Use this feature to run a report that shows whether patients who visited your office on a certain date have charges in their ledger for that date of service.

Note: *This feature can only determine whether charges were entered if the patient is pulled into the scheduler by ID#. If the patient was new and you just entered their name on the scheduler with no ID,*

the report will tell you whether or not they showed up so that you can check the ledgers to determine if charges were entered.

APPOINTMENT SETTINGS

Use this feature to define the default settings used **Q-SCHEDULE**. Additionally, you will use this screen to define provider names/rooms/equipment that you might be scheduling as well as the top 20 reasons for appointments. You will also define your Super Bill settings here.



START TIME – enter the earliest time that appointments can be scheduled daily for all providers.

> ***NOTE:*** *All of these settings are global settings for the office. So if one provider starts at 8 am and the other at 9 am, the system will have to be set at 8 am.*

INTERVALS – choose between 10 and 15 minute increments for scheduling.

END TIME – enter the latest time that appointments can be scheduled daily for any one provider.

HOLIDAYS – enter holidays observed by office. This feature will automatically block the entire day and will not allow scheduling of patients.

ACTIVE COLUMNS – This feature allows users to de-activate appointment books 2, 3 or 4 for all providers.

OTHER SETTINGS – these functions allow for turning on or off miscellaneous settings.

BLOCK WEEKENDS – blocks weekend scheduling

SHOW LEDGER TOTALS – allows for the ledger balance screen to be shown when scheduling a patient.

SHOW OFFICE MESSAGE – allows for the inner office message to be shown when scheduling a patient.

Refresh Every 15 Sec. – allows for Quick-MD to update any changes to the appointment system every 15 seconds. This feature is for a multi-user system, running on a network.

Check for Future Appointments - will auto check for the first future appointment this patient has, providing patient was pulled in by ID#.

> ***Note:*** *Depending on the size of the data base and the speed of the network, this Feature may have a tendency to slow down the scheduling process. You can, however, tune this feature using the # of Days to go out on check for future appointments feature described below.*

Print 4 column Listing - If checked this will print the appointment listing out to mirror the 4 columns of the scheduler screen. Only the patient names will print on this listing.

Default Status Code – Use this feature to set a default status code on all new appointments.

Next Super Bill # – allows user to control the next super bill number used when printing super bills from the scheduler.

of days to go out on check for future appointments- This feature allows you specify the number of days that the "Check for Future Appointments" feature will run through. This allows you to tune the application for slower networks and large databases.

> ***Note:*** *Settings of 0 or 1 will make Quick-MD scan ALL dates into the future. If you want to decrease the number of days, then settings of two or greater will turn this feature on.*

ReBuild App File – this utility allows for the appointment files to be rebuilt in the event data files are corrupted.

ReIndex App File – this utility allows for the appointment files to be re-indexed in the event data files are corrupted.

Purge App File – Use this feature to purge appointment files for a time period, if desired.

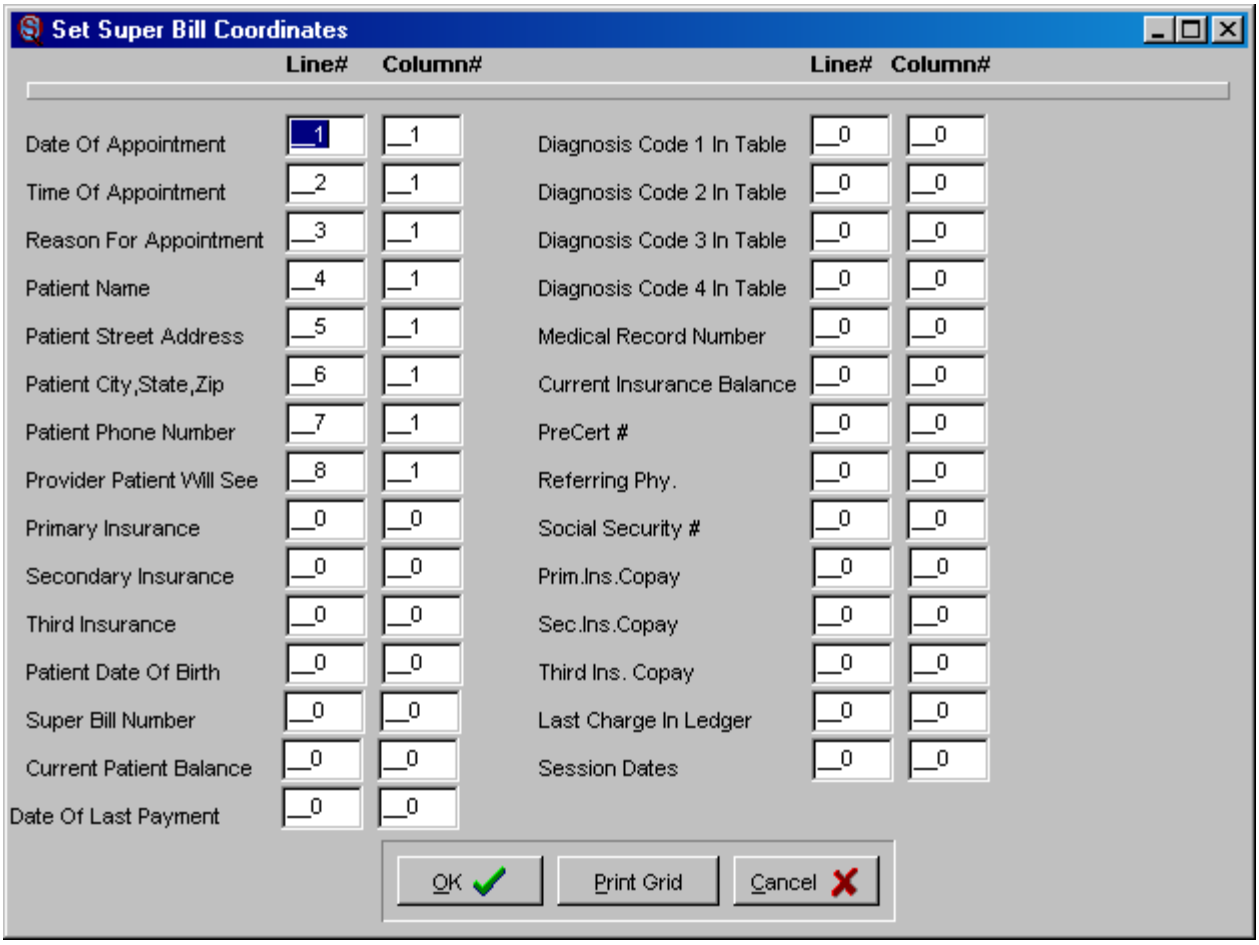
Reset Locked Fields - If a system error message occurs in the appointment file, this feature allows you to reset lock fields to clear error message and allow the user to continue.

> ***Example:*** *System error message will display "appointments locked by another terminal", and you know no one else has this day in use. This occurs when someone is scheduling an appointment and windows locks up or there is a power spike or outage, et al.*
>
> ***Important:*** *All operators except the one running this utility must be out of the Appointment System and Quick-MD!*

Set Appointment Reasons
Here is where you can setup your practice's top 20 reasons that patients visit your office. These reasons are used during the booking process. Quick-MD will automatically block out pre-set amount of times and automatically turn the appointment a color that you select. These commands are on the top of this screen.

Set Provider Names
This is where the set up is done for providers/rooms/equipment to be scheduled.

Set Super Bill Data
Quick-MD is designed to fill out your super bill with any or all of the information found on this screen.


Set Super Bill Coordinates
Line# Column# Line# Column#
Date Of Appointment 1 1
Time Of Appointment 2 1
Reason For Appointment 3 1
Patient Name 4 1
Patient Street Address 5 1
Patient City,State,Zip 6 1
Patient Phone Number 7 1
Provider Patient Will See 8 1
Primary Insurance 0 0
Secondary Insurance 0 0
Third Insurance 0 0
Patient Date Of Birth 0 0
Super Bill Number 0 0
Current Patient Balance 0 0
Date Of Last Payment 0 0
Diagnosis Code 1 In Table 0 0
Diagnosis Code 2 In Table 0 0
Diagnosis Code 3 In Table 0 0
Diagnosis Code 4 In Table 0 0
Medical Record Number 0 0
Current Insurance Balance 0 0
PreCert # 0 0
Referring Phy. 0 0
Social Security # 0 0
Prim.Ins.Copay 0 0
Sec.Ins.Copay 0 0
Third Ins. Copay 0 0
Last Charge In Ledger 0 0
Session Dates 0 0
OK
Print Grid
Cancel

Step One: Print a Test Form
Load your printer with your pre-printed Super-Bills and then click **<PRINT GRID>.** This will print the test grid out on your Super Bills. *(for more information on using the Test Grid see page 86)*

Step Two: Plug in your Coordinates
You will now decide which fields print on your forms. For each field that you want to print, plug in the appropriate line and column numbers from your test form.

***NOTE**: Entering 0 in both the line and column fields will prevent that field from printing on your forms.*

Using the Standard Appointment Scheduler

The Standard Appointment Scheduler was the original scheduler that was created in Quick-MD. Although further development will not be done on this scheduler you should not hesitate to use it if the need is there for it. It is a fully functional and powerful application in its own right.

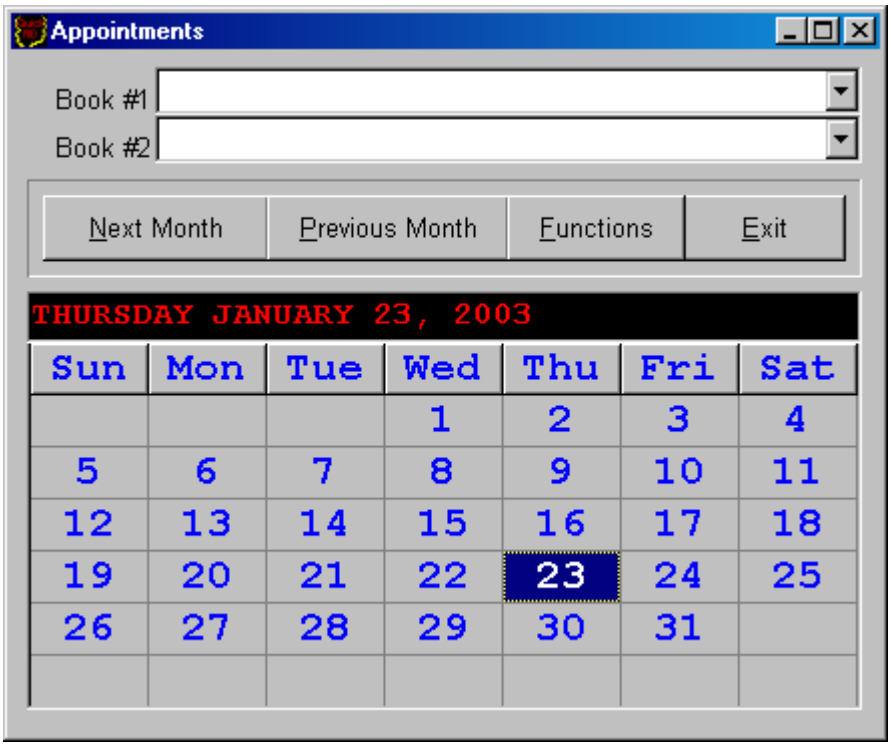
> ***Important:*** *The only reason that you would need to use this Scheduler instead of the Enhanced Scheduler, would be that the structure of your practice demands that you can see and schedule in two separate appointment books at the same time, ie. Booking for two doctors where they have to see open time slots at the same time.*

Setting Up

In order to use the Standard Appointment Scheduler, you will need to setup some basic information that tells the Quick-MD *(for more information on setting up the Standard Appointment Scheduler see page 79)*

Getting there:

From anywhere in the patient files press the ***<F12>*** key.



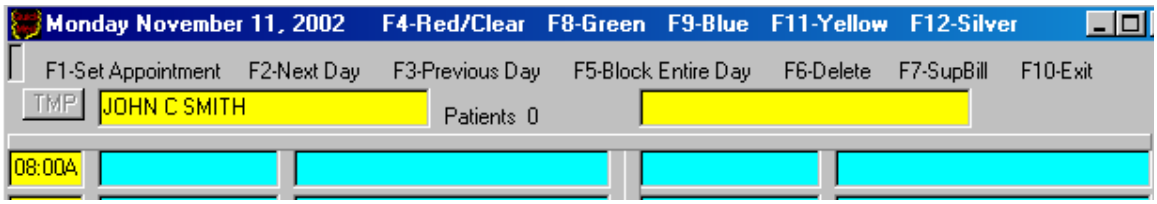
Book 1 - select the **<Down Arrow Key>** to display Provider Name and select the appropriate Provider if your office has multiple providers. All providers set up in **Provider Tables** (*for more information see page 65).*

Book 2 - you can also select the same provider if he has been set up twice in **Provider Tables** (*for more information see page 65)* with a book 2. This allows you to set appointments for two Patients with the same appointment time for this one provider or you can select another Provider to schedule appointments for.

Note: *You may select two Providers, that upon opening the scheduler, Quick-MD automatically defaults to these two books. These defaults are set in* ***Appointment Defaults*** *(for more information see page 79).*

The calendar will default to the current date. Double click on selected date to set appointments.

Note - *Commands across the top will assist you in setting appointments:*



<F1> - SET APPOINTMENT – allows for you to set an appointment in the selected time slot.

<F2> -NEXT DAY – Use this feature to set appointments for future individual days of the week

<F3> - PREVIOUS DAY – Use this feature to view previous appointments for each individual day of the week

<F4> - BLOCK/UNBLOCK - when **<F4>** is selected a first time this allows you to Block a selected time from any appointments being set. When **<F4>** is selected again on the Blocked time, this allows the time to be Un-Blocked and appointment can be set.

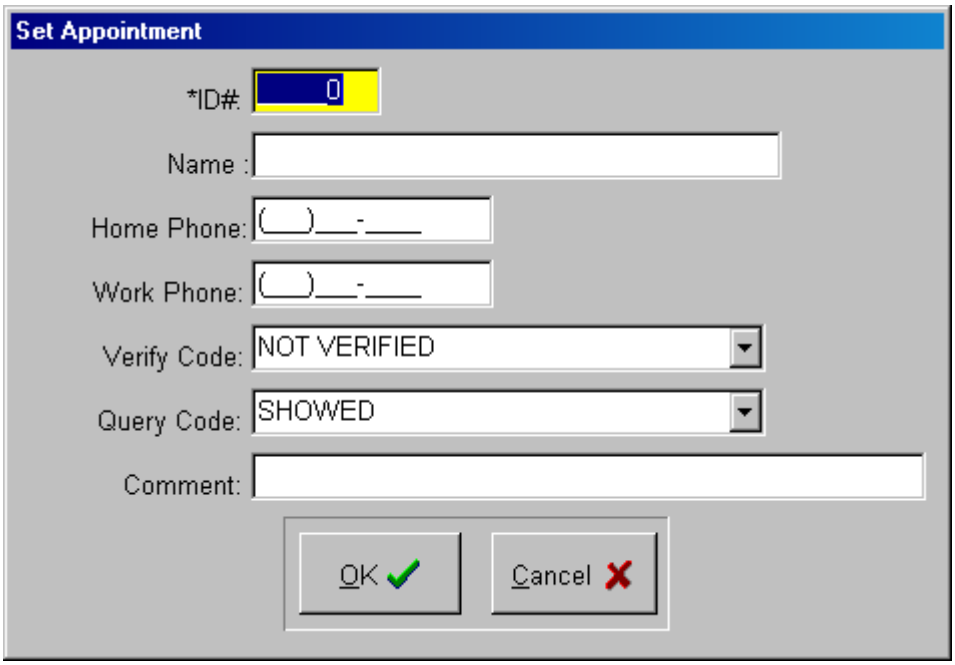
<F5> - BLOCK DAY - Use this feature to Block any day of the week from appointment being set.

<F6> - DELETE - Use this feature to delete an appointment that has been scheduled.

<F7>-SUPER BILL - Use this feature to print a single super bill for a selected patient.

<F10> - EXIT - Use this feature to return to Appointment Calendar.

Click in the time slot that you want to schedule an appointment for and select **<F1>** to Set Appointment.



ID# - select **<F1>**to browse for an established patient. Highlight the desired patient and hit enter to bring Patient's current information to appointments. Patient name and telephone number will follow.

NOTE - *While browsing "Patient Tables" you may Press* ***<F1>****to See More information on the patient that is highlighted. Also you may want to view this patient's ledger and inter office messages when scheduling. These features are turned on in* ***APPOINTMENT DEFAULTS*** *(for more information see page 79).*

If you are scheduling an appointment for a patient who is not in your system already, then skip the **ID** field and enter his name and phone number and the reason for the visit, and click **<OK>**.

VERIFY CODE – Use this feature to track whether the patient has been Verified for their appointment or not. Select the appropriate code.

- Not Verified
- Verified
- No Answer #1
- No Answer #2
- No Answer #3

QUERY CODE - Select the appropriate code: After appointment date to track all patients who either showed up for their appointments or did not show up for their appointments. Click in the desired time slot and hit the **<F1>** key to set the query code.

- **Showed -** Patient kept appointment
- **Did Not Show -** Patient did not keep appointment
- **Cancelled -** Patient cancelled appointment

COMMENTS - Enter the reason for the visit in the comments field.

Select **<OK>** and Patient name will appear in selected time area.

Quick-MD allows users to change blocks with different colors to denote whatever the office desires. The commands that allow you to do this are listed across the top bar.

> ***EXAMPLE:*** *Some offices denote surgery with green color, post op with yellow, etc. Also, some offices will change the color of the appointment to silver to indicate that the patient has checked in and is waiting to be seen.*

MOVING APPOINTMENTS

Quick-MD allows users to cut and paste appointments when moving an appointment within the schedule is necessary. To use this feature, double click in the appointment box where the appointment currently exists. Quick-MD will ask you if you want to cut the appointment. Choose yes. Then, go to the time and day that you want to move the appointment to. Double click in that time slot. Quick-MD will ask you if you want to paste the appointment. Choose yes.

USING TEMPLETS

Quick-MD allows users to utilize templates. This feature will save a layout of blocked or colored time in the schedule. Once saved, this layout will be copied to all future days that have not been opened. For example, blocking out lunch from 12:00 PM to 1:00 PM on a Monday, will block out all lunch hours for all future Mondays that have not been previously opened by a user. To use this feature, schedule initial template and click on TMP button in upper left hand corner.

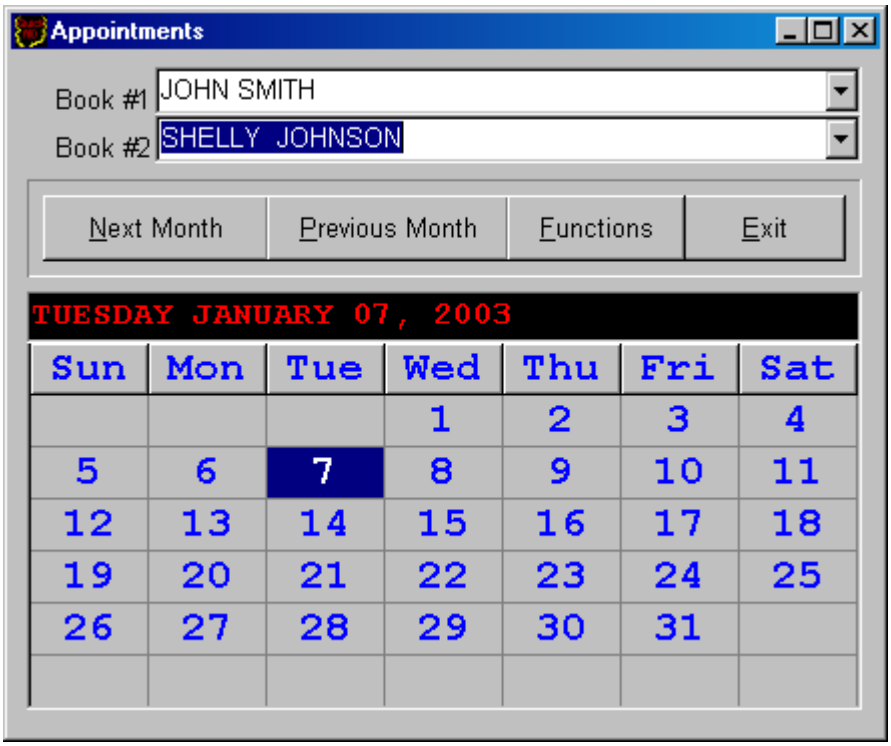
> ***NOTE:*** *For This feature to work, first go to properties and click on box, "Use Appointment Templets", before attempting to utilize This feature.*

You can apply a Templet on a day by pressing **<F11>** while the cursor is in a time slot. The menu will let you apply a templet from any day of the week.



Using the Appointment Functions

Main Menu on the Appointment Calendar


Appointments
Book #1 JOHN SMITH
Book #2 SHELLY JOHNSON
Next Month
Previous Month
Functions
Exit
TUESDAY JANUARY 07, 2003
Sun Mon Tue Wed Thu Fri Sat
1 2 3 4
5 6 7 8 9 10 11
12 13 14 15 16 17 18
19 20 21 22 23 24 25
26 27 28 29 30 31

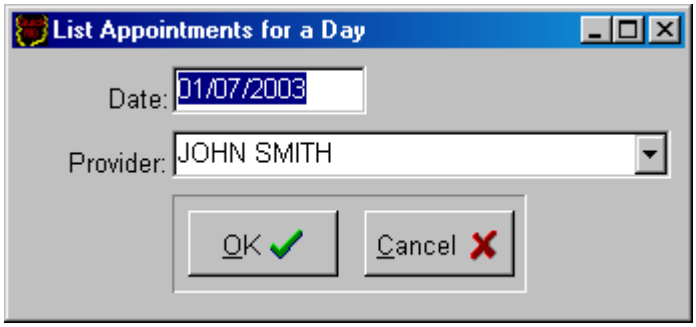
Next Month – Use this feature to make appointments for future months

Previous Month - Use this feature to view previous months appointments

Functions



List Appointments
Use this feature to Print Appointments for a Day.



Date - Enter the date of appointments you want to print.

> ***Note:*** *System will default to present date.*

Provider - Select the **<Down Arrow>** key to display Provider Name and select the appropriate provider

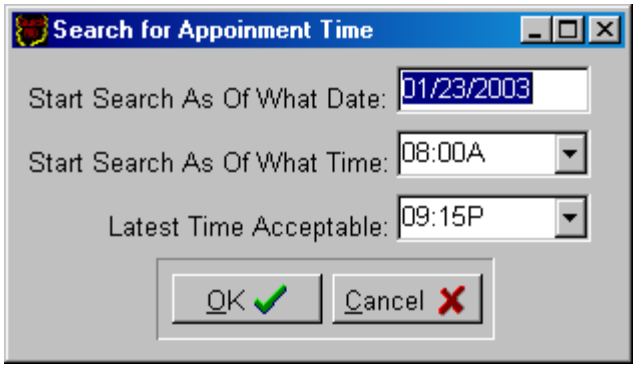
Select **<Ok>** to List all Appointments on Screen

Select **<Print All>** to Print Appointment Report

> ***Note:*** *You should have a Printed Report of all Appointments for the date you selected.*

Select **<Close>** to return to Appointment Reports Menu

Search For Appointments - Use this feature to search for next available appointment time, assuming all time slots not available for seeing patients have been blocked.



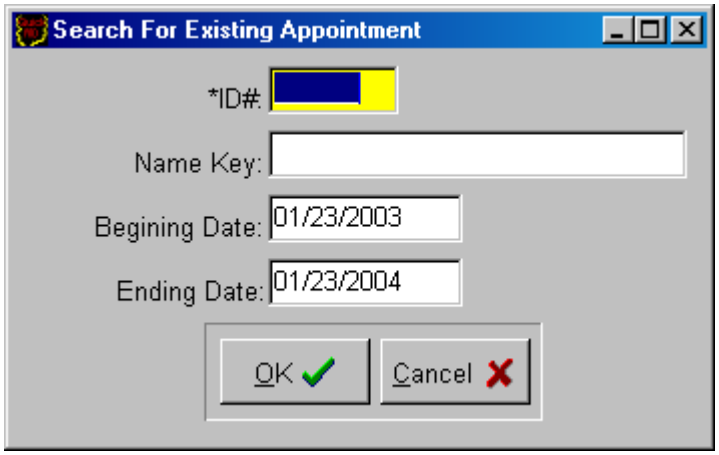
Start Search as of What Date - pick date to start search

Start Search as of What Time - use the **<Down Arrow Key>** to display the earliest time you can make an appointment

Latest Time Acceptable - use the **<Down Arrow Key>** to display the latest time an appointment can be made.

Select **<Ok>** to display Appointment Schedule

Search For Patients - Use this feature to view an existing appointment for a patient.



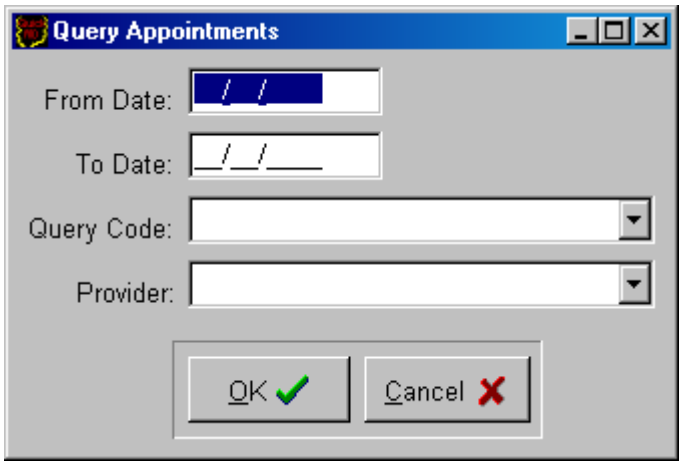
In the yellow field you may use the **<F1>**key to browse your Patient Tables, highlight the patient you want, then hit the enter key to start your search, or if the patient is not in your patient files, you may search for his/her appointment by Name. The name search will search on a partial spelling of the name.

Quick-MD defaults to today's date as a beginning date for the search.

Ending Date - enter the date you want Quick-MD to end search.

Select **<Ok>** to display all appointments set for this patient.

Query Appointments
This feature is used for reporting purposes.



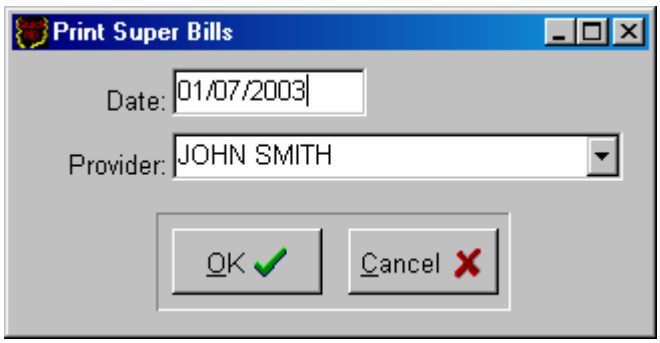
FROM DATE - select the date you want to begin your report.
TO DATE - select the date you want to end your report.
QUERY CODE - select the appropriate query code.
PROVIDER - select the appropriate provider.

Select **<OK>**

The **DATA OUTPUT PROCESSOR** will display all patients with the selected date of appointments and the selected Query Code.

Select **PRINT ALL** to print report or Select **CLOSE** to exit

PRINT SUPER BILLS - Use this feature to print Super Bills for all patients with appointments on the selected date.



DATE - select the date of appointments Super Bills are to be printed

PROVIDER - select the appropriate provider that Super Bills are to be printed. To print Super Bills select appropriate Printer, then select **<OK>** to print Super Bills

NOTE: *Always select* **EXIT** *to exit Appt Reports Menu and return to Appointment* ***Calendar.***

NOTE: *There is a cut and paste function available in the appointment scheduler that allows you to move a patient from one appointment to another. Double click with the left mouse key on the time period that the appointment is currently set for. Go to the new time period and double click with the left mouse key. Quick-MD will prompt you to paste. Choose* **<OK>** *and the appointment is moved.*

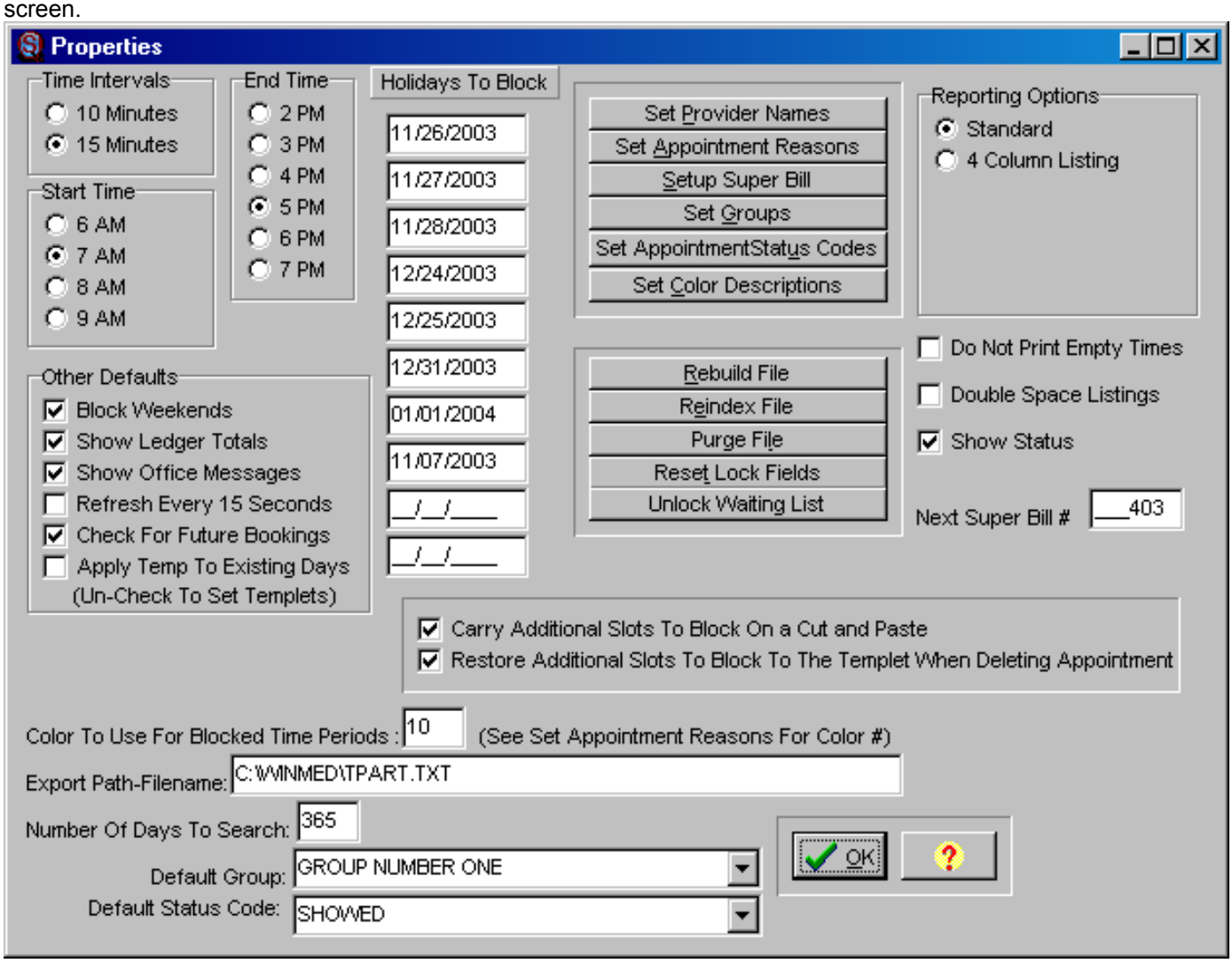
Once patients are scheduled, click in a desired time slot, and hit the **<F1>**key to view this patients' information.

Multi-View Scheduler

Getting there:
The Multi-View Scheduler is a separate, but integrated, application that is started from its own icon. Set an icon to "books.exe' in the medical folder. When open, this Scheduler operates on a separate tab on the tool bar, which allows for access to it while working anywhere in Quick-MD or any other program.

Setting Up

The setting for the appointment can be found by clicking on the properties button. This will bring up the following screen.



Time Interval: - The time interval can be set to ten or fifteen minutes. Once the time interval is set it should not be changed.

Start Time / End Time: - The Start and End times set the default start and end times for all doctors.

Holidays To Block: - Stores up to ten holidays. User cannot book appointments on holidays.

Other Defaults:

- **Block Weekends: -** If checked the user will not be able to book appointments on the weekend.
- **Show Ledger Totals: -** If checked the ledger totals for the current patient will be displayed when booking their appointment.
- **Show Office Message: -** Show any office messages that belong to the patient being booked.

- **Refresh Every 15 Seconds: -** If this is checked the appointment screen well refresh itself every 15 Seconds. This will keep terminals in sync if there are more then one users booking appointments.
- **Check For Future bookings: -** When the appointment is booked the system will search for any appointments for this patient in the future. If a future appointment is found the system will warn the user.
    - ***Note****: The feature only works for appointments that are set using the patient's ID.*
- **Apply Temp To Existing Days: -** If this feature is checked, the templet on existing days will be automatically updated with any changes made to the templet.
    - ***Note:*** *When creating templets it is best to have this option disabled. If it is enabled then the system will refresh while you are creating an appointment, effectively erasing your current template. Also, if you are assigning a templet using the* ***<F11>*** *then you will need to book an appointment to keep it from getting automatically refreshed with the default templet.*

Carry Additional Slots To Block On a Cut and Paste: - If this option is checked cut and paste will carry all of the slots associated with the current appointment.

Restore Additional Slots to Block to the Template When Deleting Appointment: - If this option is checked the book will be restored to the template settings when an appointment is deleted.

Color To Use For Blocked Time Periods: - This is the color that the system will use when blocking appointments you can get the color code by checking Set Appointment Reasons. *(for more information see page 128)*

Export Path-Filename: - This is the file that is written to when you run the **Third Party Export**. *(for more information see page 139)*

Number of Days To Search: - This is the maximum number of days that the system will search when checking for future bookings.

Default Group: - This is the group that will be displayed whenever the appointment system is first started.

Default Status Code: - This is the status code that will be used by default whenever a new appointment is created. *(for more information see page 130)*

Reporting Options: - These two options affect the List Appointments for a Day report. *(for more information see page 137)*

- **Standard: -** Prints a single column view of the appointment system.
- **4 Column Listing: -** Prints a four-column view of the appointment system.

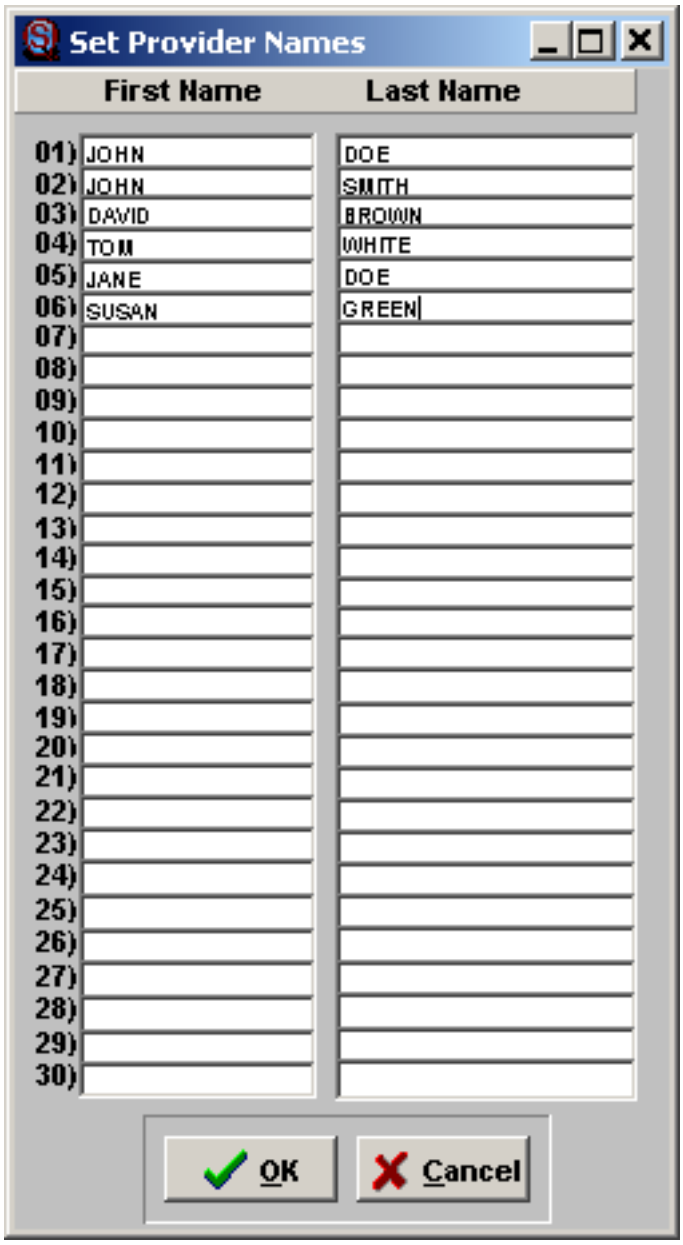
Do Not Print Empty Times: - If this option is set, empty appointment times will not show up on the List Appointments for a Day report. *(for more information see page 137)*

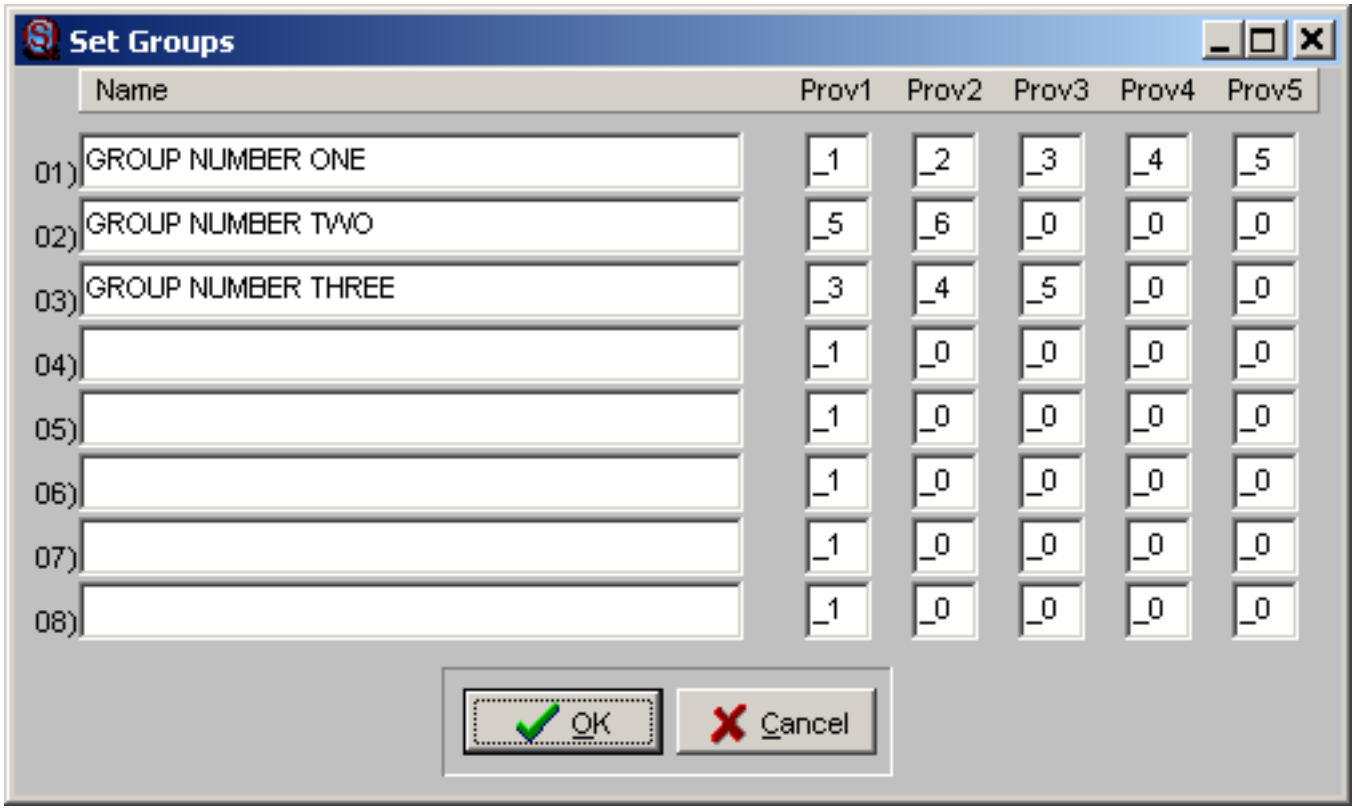
Double Space Listing - If this option is set there will be extra space between each appointment on the List Appointments for a Day report. *(for more information see page 137)*

Show Status – If this option is set the status for the appointment will print on the List Appointments for a Day report.

Set Provider Names

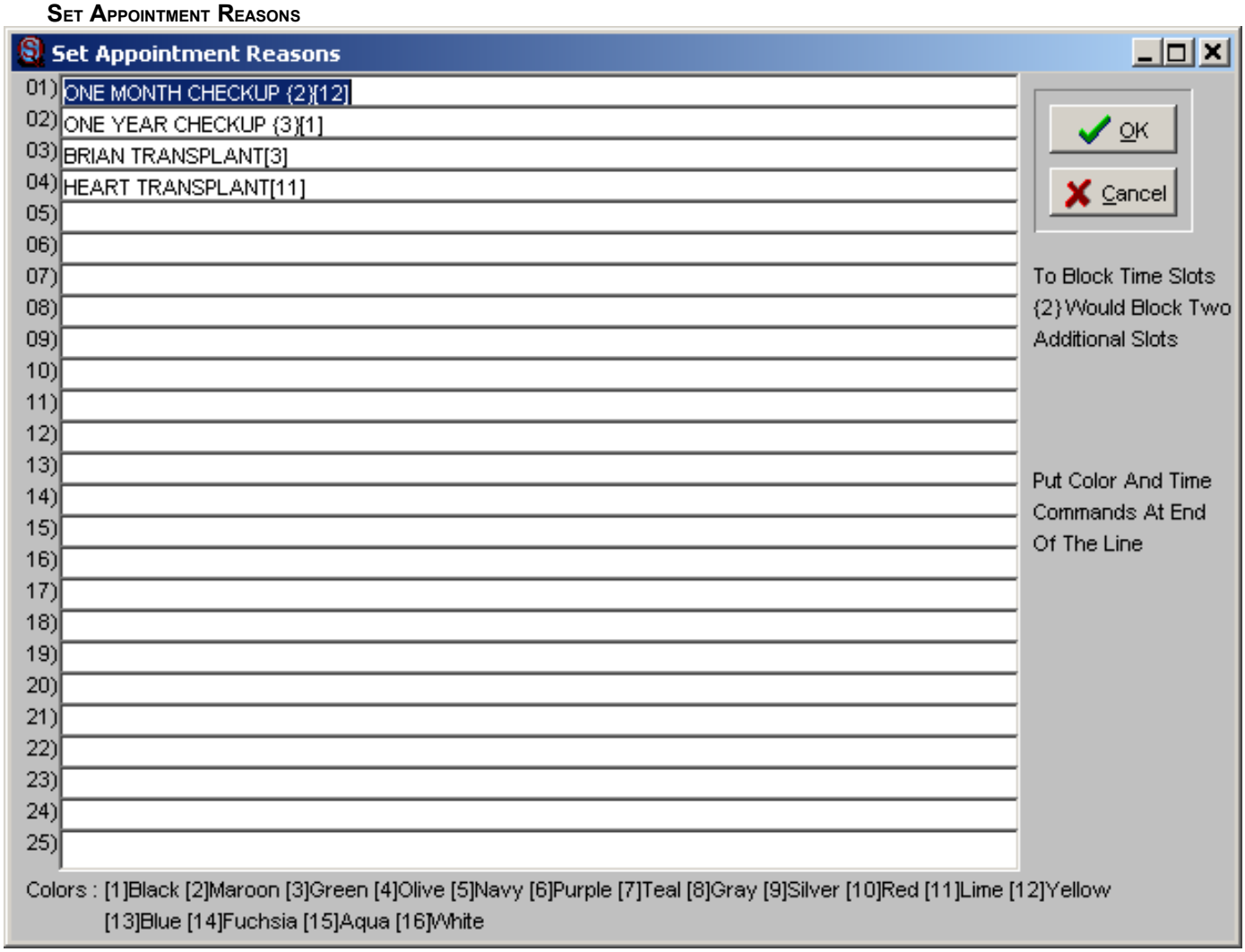
The appointment system allows you to book appointments for up to thirty providers.





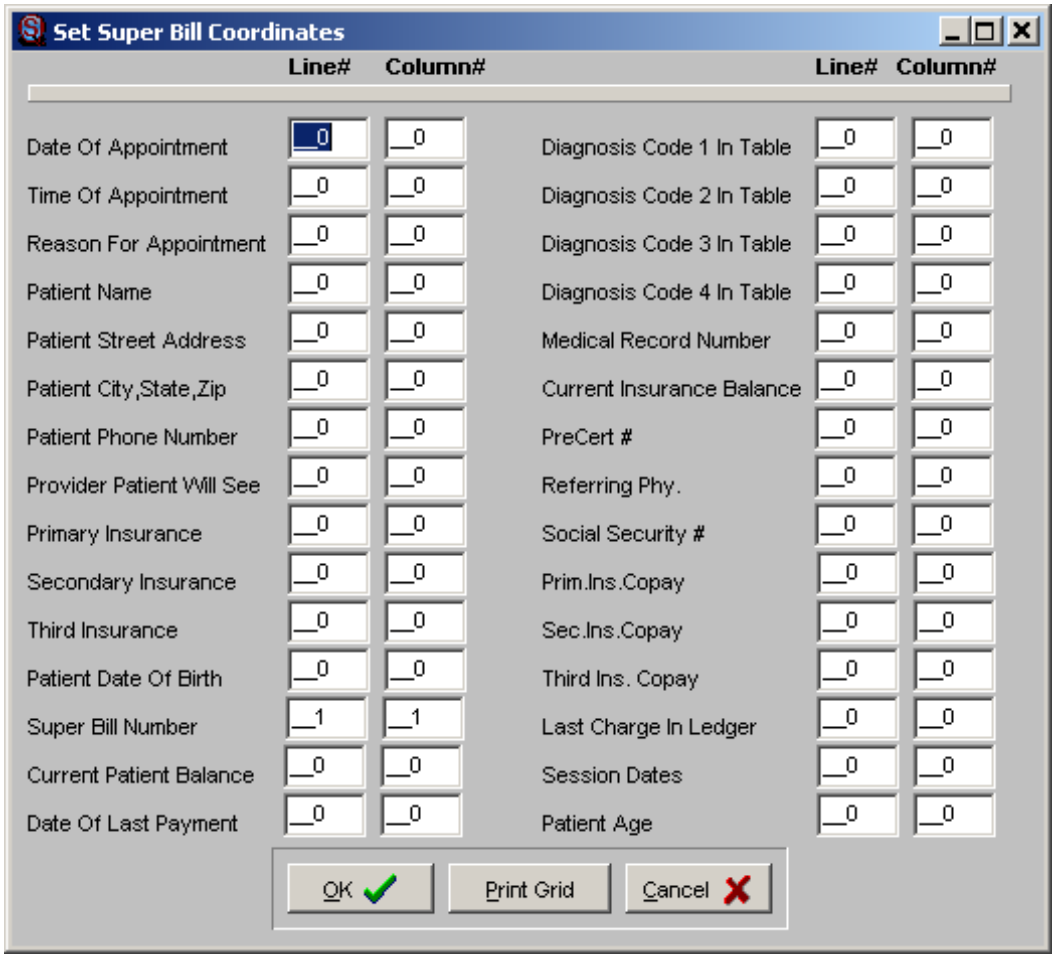
This allows you to set up groups of providers. Each provider in this group will be displayed in a book on the main screen. Prov1 corresponds to the first book, Prov2 the second book, and so on. The provider numbers here correspond to the provider numbers in the set provider screen. *(for more information see page 125)*

SET APPOINTMENT REASONS



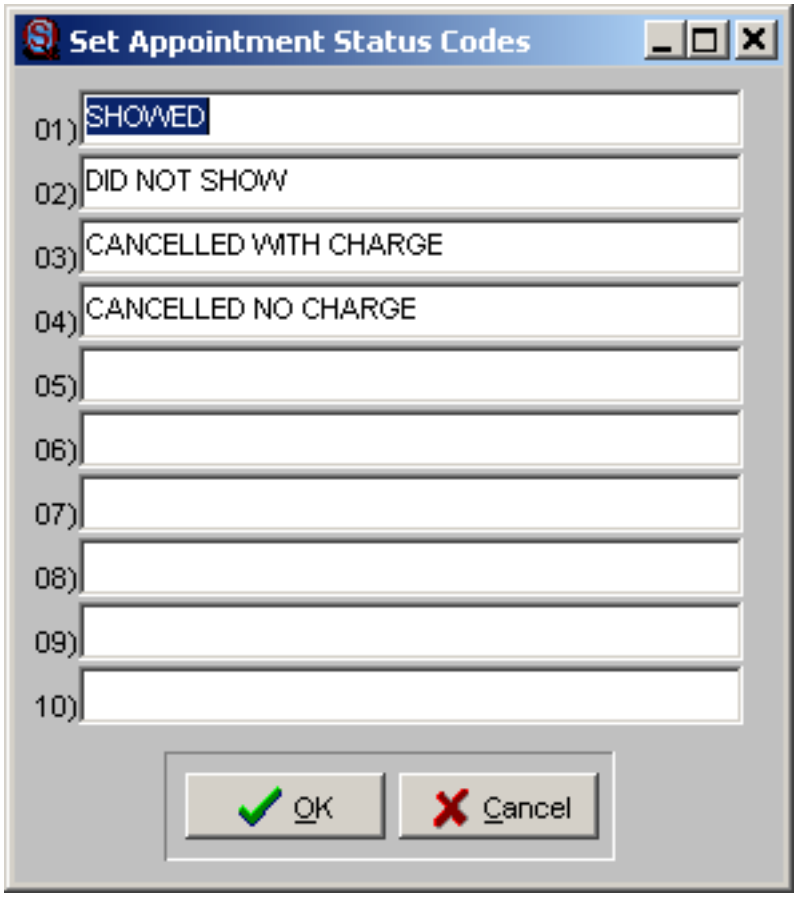
You can have up to 25 custom reason codes. Each reason code can have a color and a number of slots to block associated with it. There are 16 standard colors that you can use. You can associate the color by adding a number in square brackets at the end of the descriptions. The color codes are listed at the bottom of the form. If you want the reason to default to a certain number of blocks, you can set a number in parentheses at the end of the description. For example, if you wanted to have new patients colored green and to take up two blocks, you would enter the following description, “New Patients {2}[3]”.

Setting Super Bill Coordinates



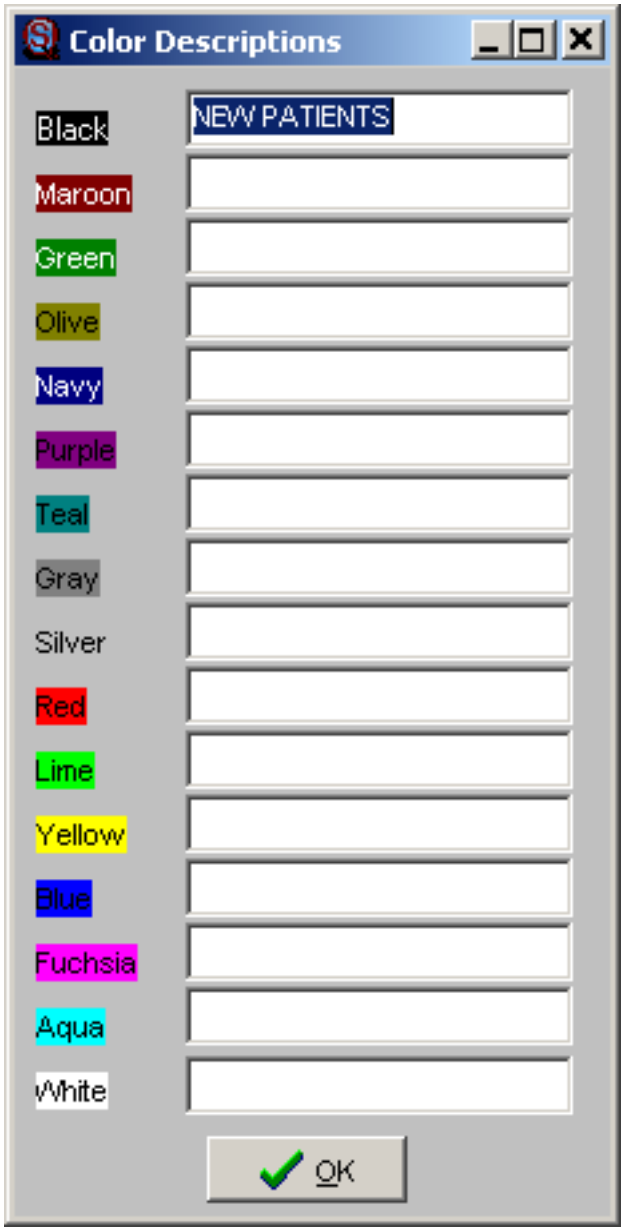
This screen will allow you to setup the layout of your super bill. *(for more information see page 115)*

SET STATUS CODES



Quick-MD we allow you to set up to 10 custom status codes. The codes entered here will show up on the appointment information screen. *(for more information see page 133)*

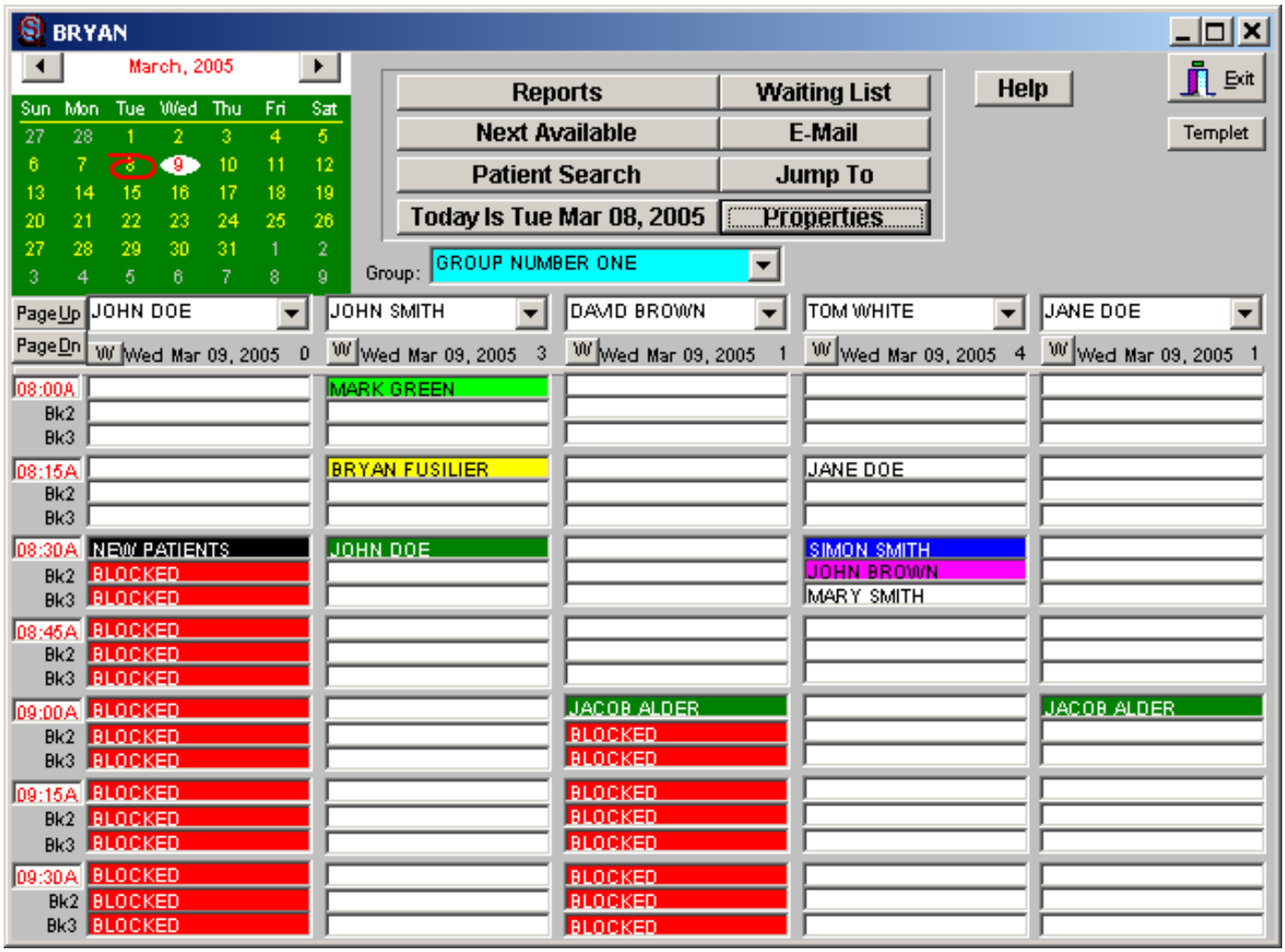
Set Color Description



This form allows you to set up a description for a color. This way you can assign certain times to certain types of visit by using a specific color for that time. When a color with a description is used the description is displayed if there is not any patient information for that block.

File maintenance utilites

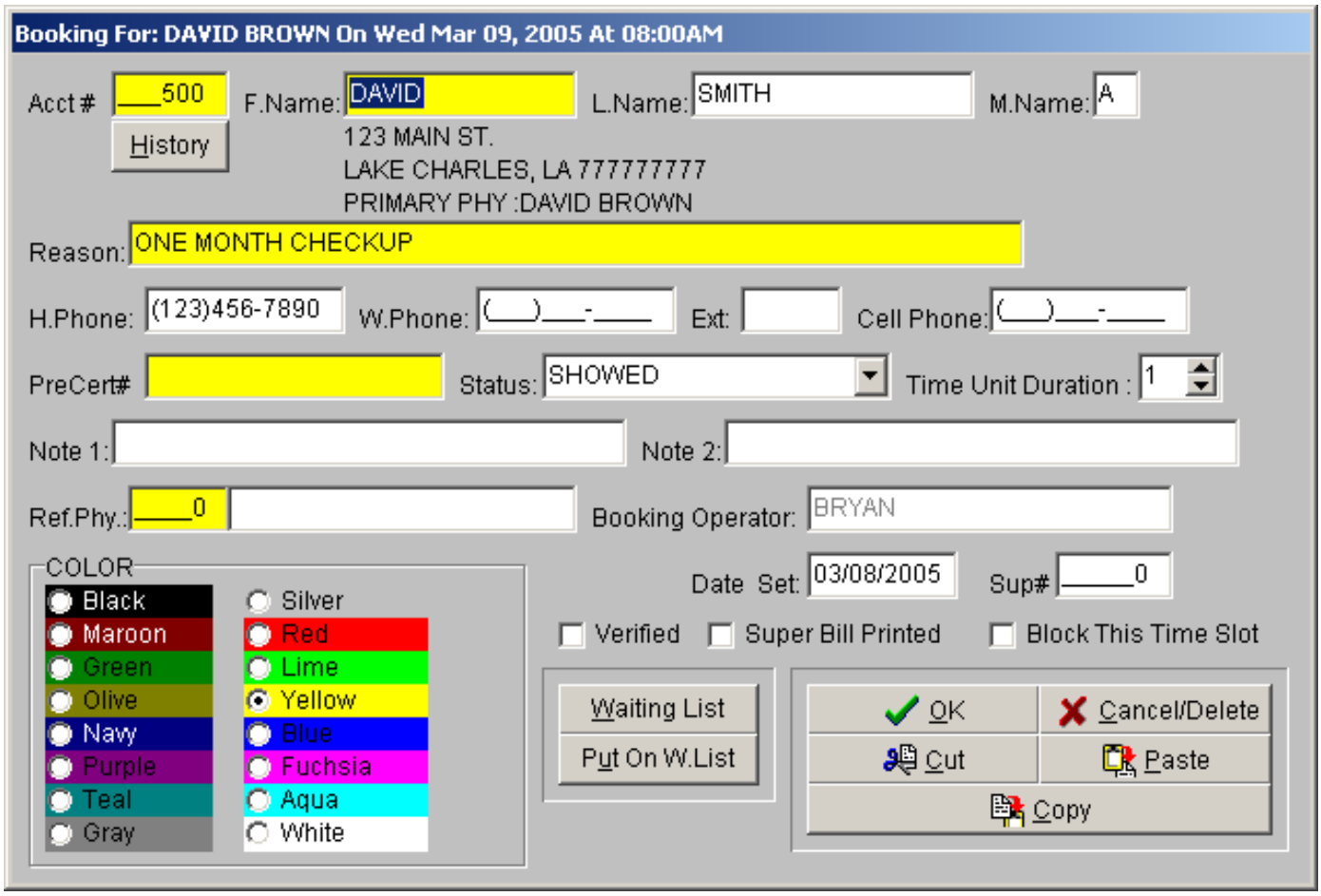
- **Rebuild: -** Allows you to rebuild the appointment files. *(for more information see page 284)*
- **Re-index: -** Allows you to re-index the appointment files. *(for more information see page 285)*
- **Purge Files: -** Allows you to remove old information from the appointment system. Once this information is gone there is no way for the system to access it unless you restore from a backup. You should only purge old appointments if you are sure that you will no longer need this information.
- **Reset Lock Fields: -** You may need to run this utility if you are getting locking errors while trying to book appointments. The appointment files may get stuck in a locked state due to system failures such as lose of power.
- **Unlock Waiting List: -** You may need to run this utility if you are getting locking errors while working in the waiting list.



Each book is set to a provider that comes from a particular group. *(for more information see page 127)* The "w" button above each book will put the appointment system in **WEEK MODE**. **WEEK MODE** will allow you to see the whole week for a single doctor. To return to **GROUP MODE** you need to pick a group.

The calendar is shown in the upper left hand corner of the form. The current date is always circled in red. At anytime, to quickly return to the current date, click on the button that says, "Today is" followed by the current date.

CREATE AN APPOINTMENT
Double click in the time slot where you want to create an appointment.



Acct# - Enter the patient's account number if you know it or Select **<F1>** to bring up the **LOOK UP PATIENT FILE SCREEN** where you can search for the patient in your database. *(for more information on using the **LOOK UP PATIENT FILE SCREEN** see page 211)*

> ***IMPORTANT:*** *If you are scheduling an appointment for a patient who is not in your system, then enter through the **ID#** field and simply enter the new patient's name, phone number and the reason for the visit. This allows you to schedule patients without setting them up in the system first. If the patient does not show up for the visit then you have not wasted an Id number, nor lost the time to set them up un-necessarily.*
>
> ***NOTE*** *: Also you may want to view this **Patient's Ledger Balances** and **Inter Office Messages** when scheduling, if brought in by Acct#. These features are turned on in **PROPERTIES** (for more information see page 124)*

F.NAME – Once the patient has been pulled into the scheduler by Acct#, this field will be populated with the patient's first name. If you are scheduling an appointment for a new patient, one that is not already setup in Quick-MD, you can type the patient's name here.

> ***NOTE:*** *If your cursor is in the name field, and the patient has been pulled into Multi-View by ID#, you can hit **<F1>** to verify and even edit the patient's demographics from this field while you are scheduling your appointments.*

History – This feature allows you to see a complete history of this patient's appointments.

Reason - Enter the reason for the visit in the comments field or hitting **<F1>** will open the **Appointment Reason Table** where you have already setup your top 25 Appointment Reason Codes. *(for more information see **Settings** on pg 128)* Type the number of the appointment reason listed and hit **<Enter>**.

> ***Note:** If Quick-MD is setup to interface with a third party EMR you can enter a time behind the reason code and this appointment will be set at that time in the EMR. For instance if you book someone for 8:00 but type 6:00A behind the reason the appointment will be booked for 6:00 am in the EMR.*

Verification - Select the appropriate code when patient is notified of appointment: When verifying appointments, click in the desired time slot and hit the **<F1>** key, to view this patient's information. If you click on verified, an asterisk (*) will appear on the main screen next to the patient's names that have been verified, making it easy to see who is verified and who isn't.

Ref. Phy. - Enter the **ID#** of the referring physician, if known, or hit **<F1>** to browse the referring physician table. If the referring physician is not in your system, you can simply hit **<F10>** to add them from here.

Pre Cert# - Hit **<F1>** to open Quick-MD's **Managed Care Module** to either setup or select a pre-authorization code for this visit. Double click on the authorization number that applies to this visit and the system will automatically bring over both the referring physician and the authorization number. Or if you know it, simply type in the authorization number. Once set on the booking screen, the authorization number can now print on the super bill, as this is necessary information needed during the charge entry process.

Status Code - Select the appropriate code: To track all patients who either showed up for their appointments or did not show up for their appointments. Double click on a time slot to open the appointment details screen where you can now set the query code. This is usually done at the end of the business day, or as an appointment comes due, so that the appropriate selection can be made. This feature is for reporting features only. *(for more information on setting up **Status Codes** see page 130)*

> ***Note:** Some offices will set up a book called cancellations, and move cancellations to this book to keep the cancelled patient in reporting, making that time slot available for another booking.*

Color Code - choose a color that you would like the shade of that appointment field to be. These appointments can have preset colors and a preset amount of time blocked out. This is done in the **Scheduler Settings**, **Set Appointment Reasons**. The commands are listed there for the setup. *(For more information see page 128)*

Note1, Note2 – Two notes can be store with each appointment.

Time Duration – Allows you to extend the appointment over multiple units.

Booking Operator – This is the name of the current user.

Date Set – This is the date that the appointment was entered into the system.

Sup# - This is the number of the super bill that was printed for this appointment.

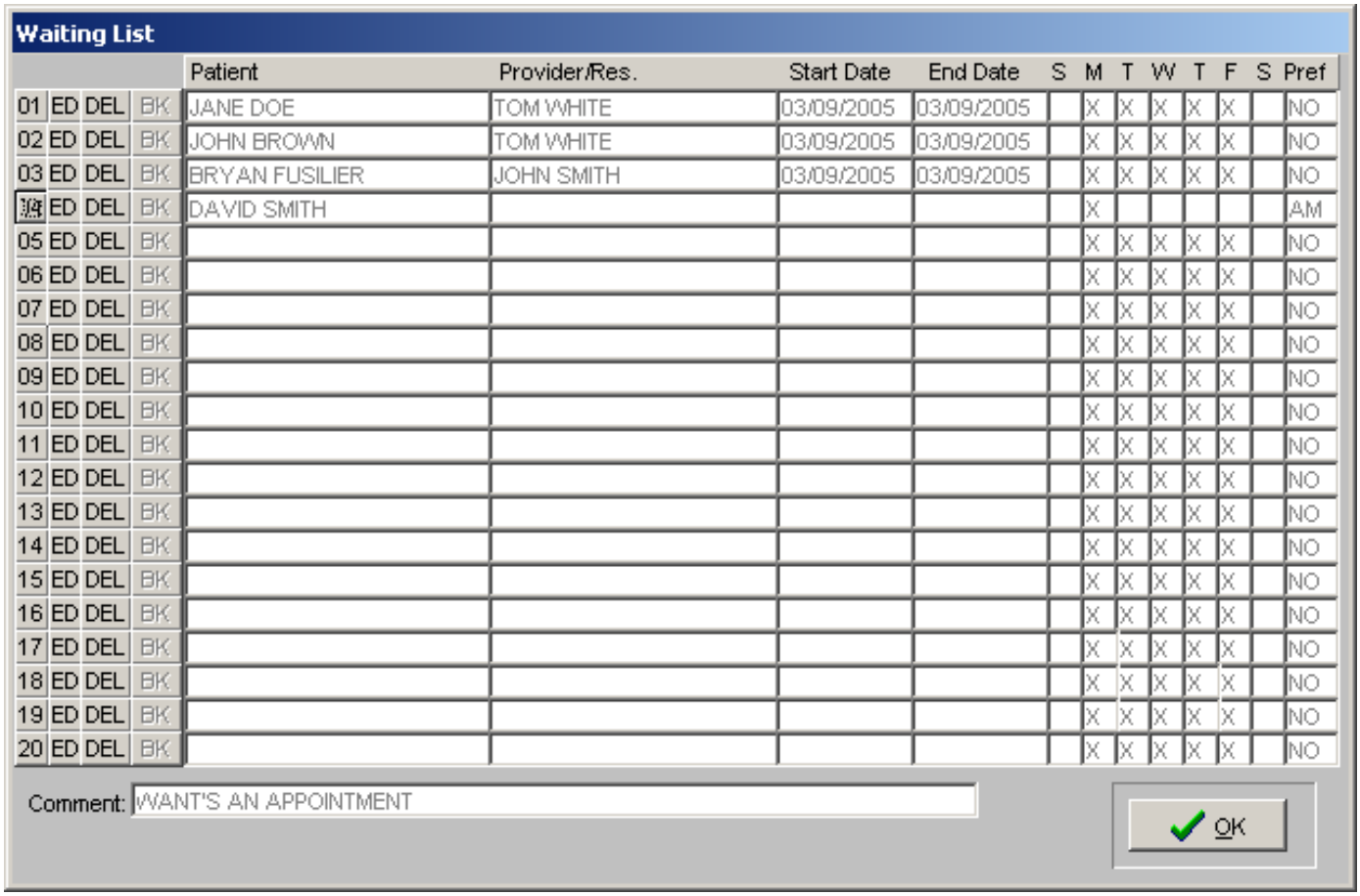
Super Bill Printed – If this box is checked a super bill has been printed for this appointment.

> ***Note:** If a super bill has been printed for an appointment a $ will appear before the patients name on the main appointment screen.*

Waiting List – This will bring up the **Waiting List.** *(for more information see page 135)*

Put on W.List – This will but the current patient on the waiting list. *(for more information see page 135)*

Waiting List


Waiting List
Patient
Provider/Res.
Start Date
End Date
S M T W T F S Pref
01 ED DEL BK JANE DOE TOM WHITE 03/09/2005 03/09/2005 X X X X X NO
02 ED DEL BK JOHN BROWN TOM WHITE 03/09/2005 03/09/2005 X X X X X NO
03 ED DEL BK BRYAN FUSILIER JOHN SMITH 03/09/2005 03/09/2005 X X X X X NO
04 ED DEL BK DAVID SMITH X AM
05 ED DEL BK X X X X X NO
06 ED DEL BK X X X X X NO
07 ED DEL BK X X X X X NO
08 ED DEL BK X X X X X NO
09 ED DEL BK X X X X X NO
10 ED DEL BK X X X X X NO
11 ED DEL BK X X X X X NO
12 ED DEL BK X X X X X NO
13 ED DEL BK X X X X X NO
14 ED DEL BK X X X X X NO
15 ED DEL BK X X X X X NO
16 ED DEL BK X X X X X NO
17 ED DEL BK X X X X X NO
18 ED DEL BK X X X X X NO
19 ED DEL BK X X X X X NO
20 ED DEL BK X X X X X NO
Comment: WANT'S AN APPOINTMENT
OK

The waiting list allows you to put patients on the waiting list that already have an appointment, but would like to have one at an earlier time.

Patient – The Patient's name is displayed in this field.

Provider/Res. – Displays the provider's name for this patient's existing appointment.

Start Date – This is the Starting Date of the current patient's existing appointment.

End Date – This is the Ending Date of the current patient's existing appointment.

S, M, T, W, T, F, S – The first letter for each day of the week. If an 'X' appears in this column then the current patient would only like an appointment on that day of the week.

Pref – This is the preferred time of the day that the current patient would like an appointment on.

Number – Clicking on the number to the left of the patient's name allows you to see the comment for that appointment. The comment will show up in the comment field at the bottom of the screen.

ED – Allows you to edit the waiting list information for the current patient.

DEL – This will delete the patient from the waiting list.

BK – This will book the patient in a selected time slot. This option is disabled unless you access the waiting list from the appointment information screen. *(for more information see page 133)*

Adding a Patient to the Waiting List

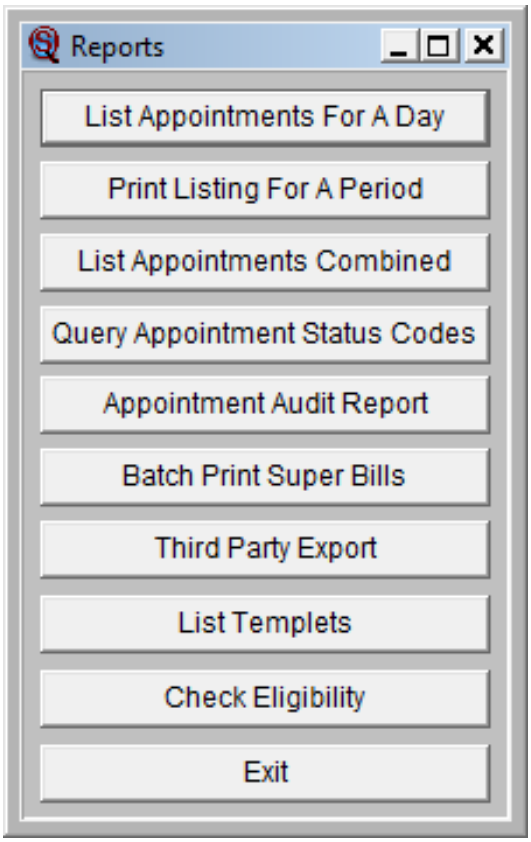
To add a patient to the waiting list you first need to book an appointment for that patient. Then on the Appointment information screen you simply click on the "**Put on W.List**" option and the patient will be added to the waiting list. *(for more information see page 133)*

Booking a Patient from the Waiting List

To book a patient from the waiting list you first need to choose a time for the appointment. Then enter the appointment information screen by double clicking. From the appointment information screen you will need to choose the "**waiting list**" feature. *(for more information see page 133)* Finally, you will need to click the **BK** button next to the patient that you want to book. *(for more information see page 135)*

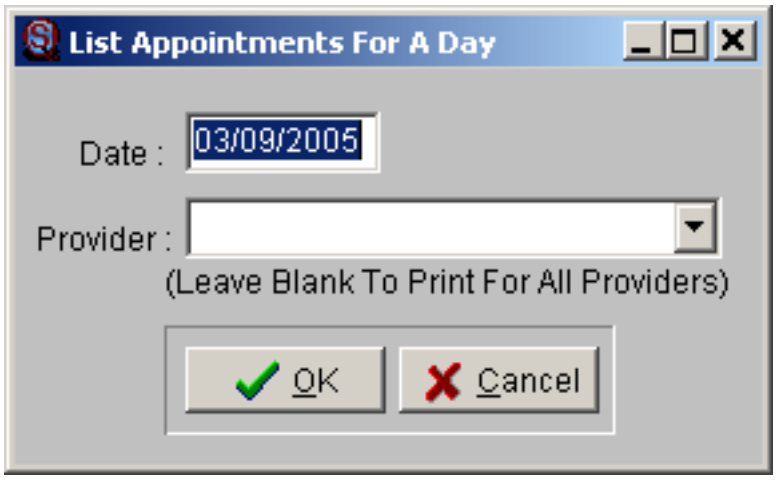
> ***Note*****:** *When a patient is pulled from the waiting list, the previous appointment for that patient will be deleted.*

Appointment Reports



List Appointments For a Day

This report allows you list all appointments for a day for a single provider or for all providers if the provider field is left blank.

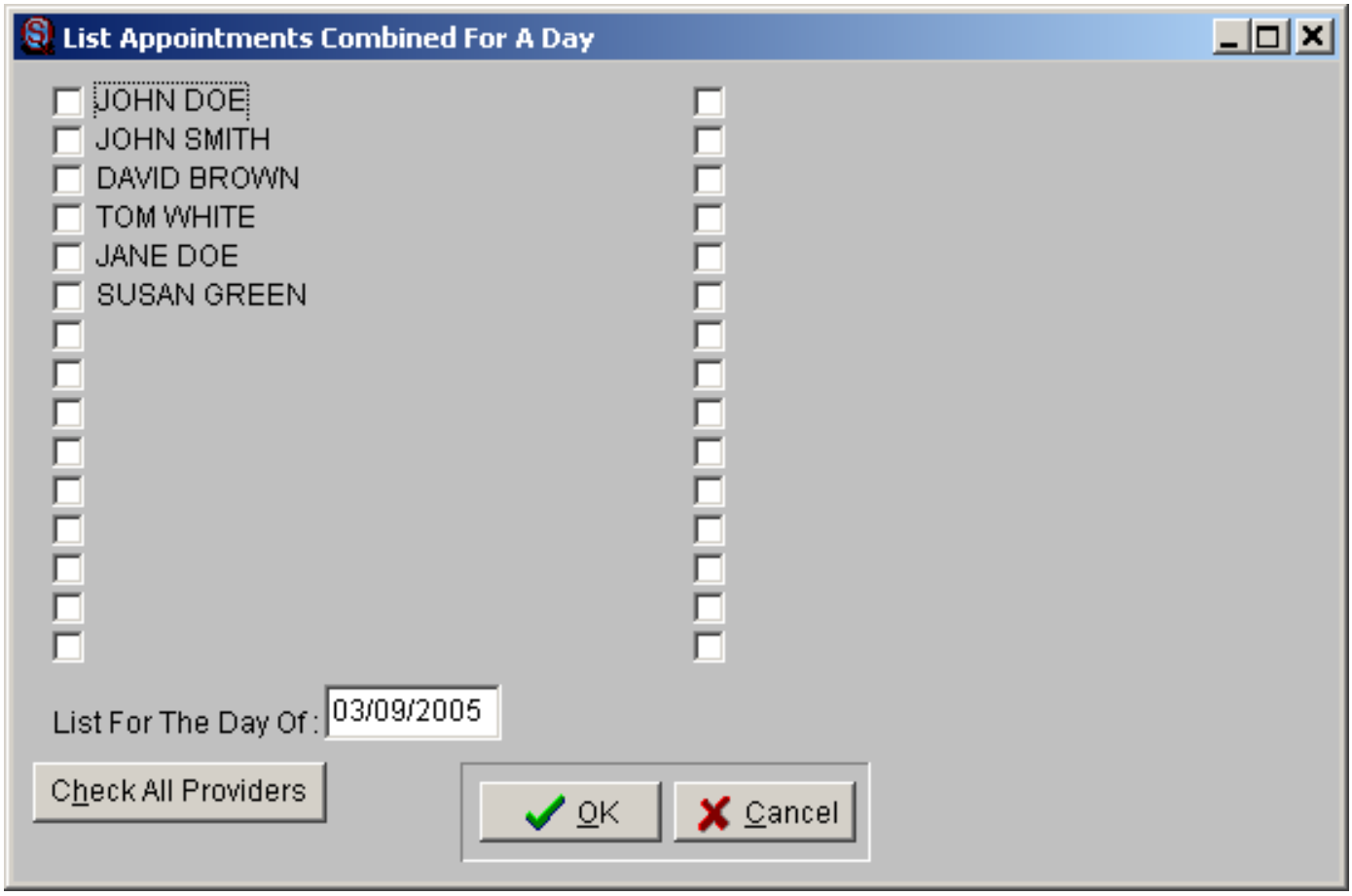


Print Listing for a period

This report runs the Day Listing for every day in the range specified.

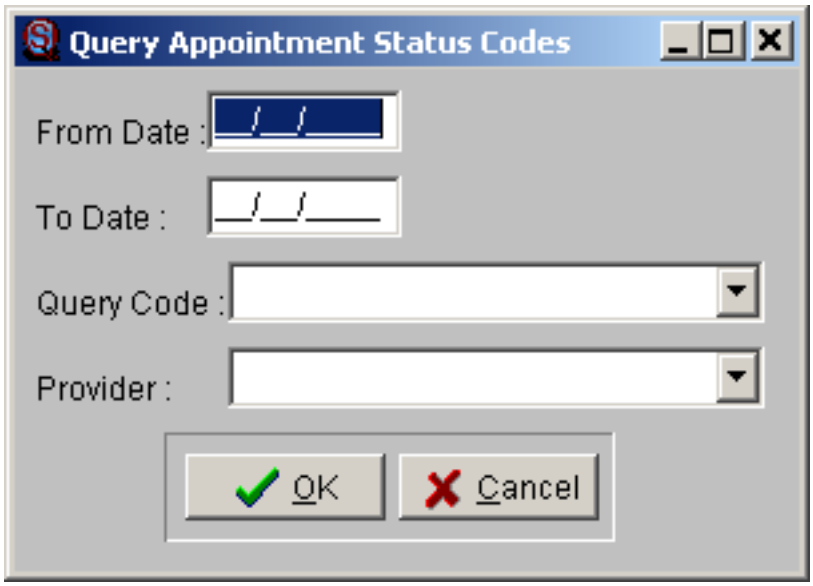
List Appointments Combined

This feature allows you to print a combined appointment list. A combined appointment list will show all appointment for all of the providers checked, per time slot.



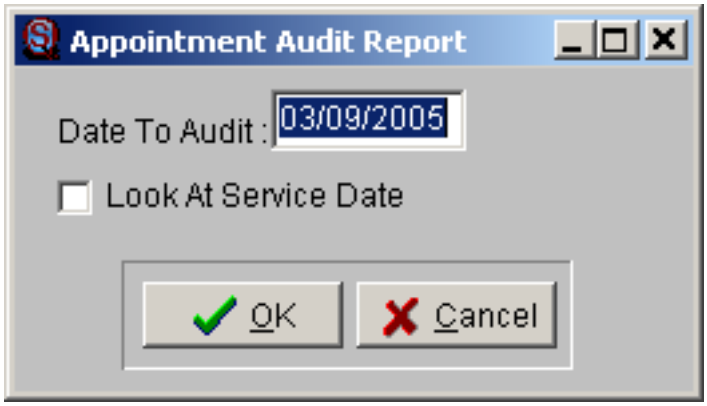
Query Appointment Status Codes

This report allows you to list all of the appointment in a date range that match the provider and the query code selected.



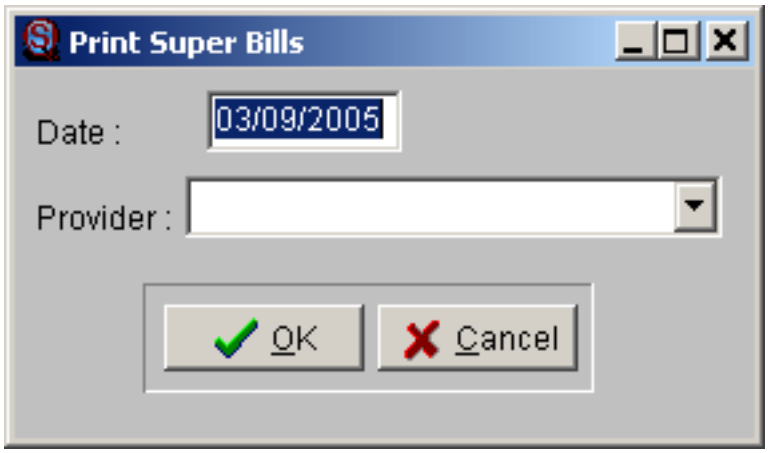
Appointment Audit Report

This report will show a list of patients on the day selected that do not have charges for that day in their ledger.



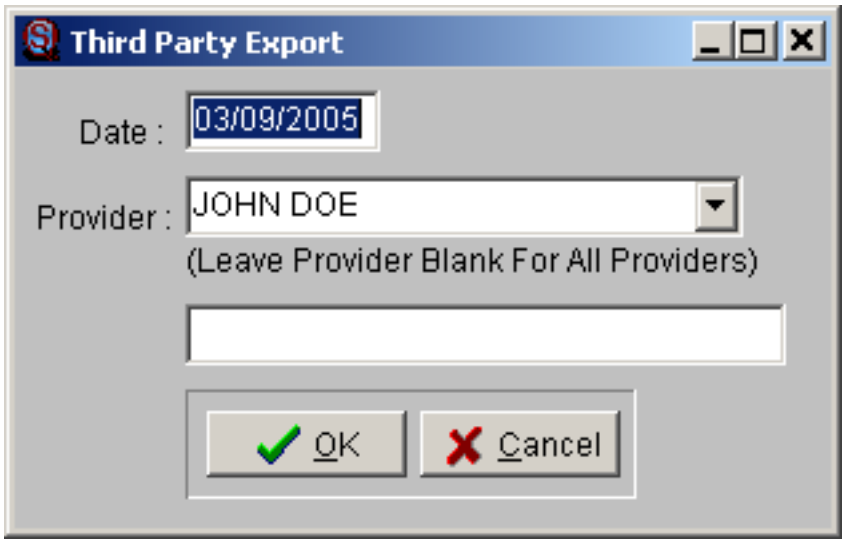
Batch Print Super Bills

This feature allows you to run a super bill for all appointments on the day selected. If the provider is blank super bills for all providers will be printed.



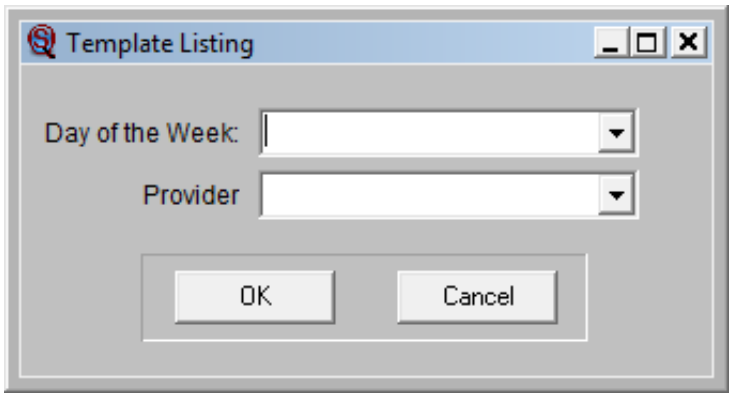
Third Party Export

This feature will generate an import file for Televox. If the provider field is blank it will export all provider's appointments on the day selected.



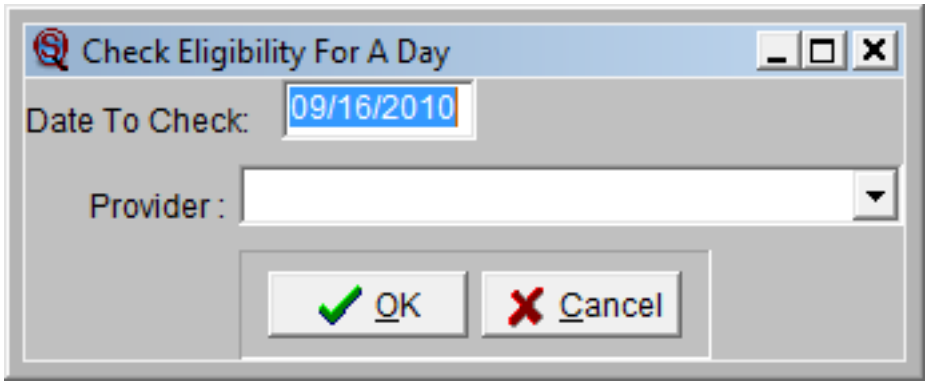
List Templets

This report will generate a text representation of the doctor's templets for a selected day of the week.



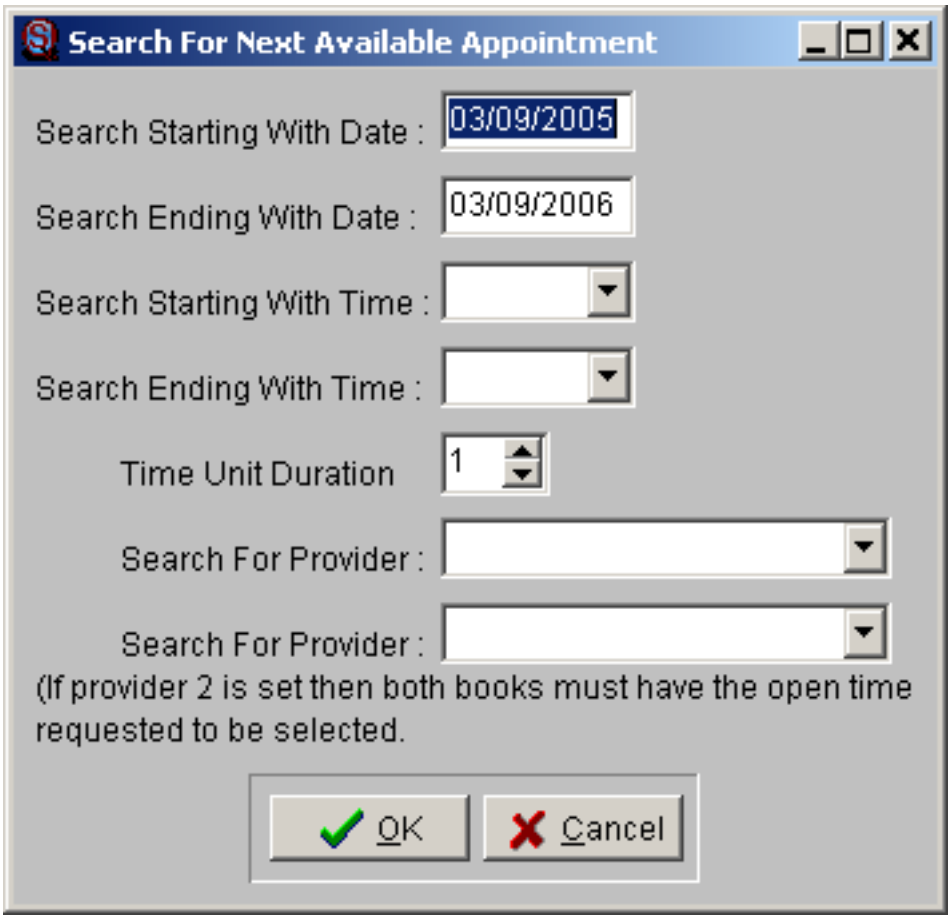
Check Eligibility

If you are using Gateway EDI as your clearing house then you have the option to check eligibility with in the scheduler. All of the existing patients for the day selected will be sent to gateway. You will get a report back for each patient explaining their current primary insurance eligibility.



Next Available

This feature allows you to search for the next available appointment time.


Search For Next Available Appointment
Search Starting With Date :
03/09/2005
Search Ending With Date :
03/09/2006
Search Starting With Time :
Search Ending With Time :
Time Unit Duration
1
Search For Provider :
Search For Provider :
(If provider 2 is set then both books must have the open time requested to be selected.
OK
Cancel

Search Starting With Date – This is the date that the system will start searching from.

Search Ending With Date – This is the date that the system will search too.

Search Starting With Time – This is the time that the system will start searching from.

Search Ending With Time – This is the time where the system will stop searching.

Time Unit Duration – The appointment must have at least the number of units listed available.

Search For Provider – If a provider is selected here; the system will search for an available appointment for this provider only.

Search For Provider Two – If a provider is selected here; the appointment system will allow the search to find open times for this provider also.

Note: *If provider two is set then both books must have the open time requested to be selected.*

Patient Search

The Patient Search lets you search for an appointment for a specific patient.


Search For An Existing Appointment
Patient Acct.#
Last Name Key :
First Name Key :
You may do partial name searchs with the last and first name keys. For example if GOOD was entered in the last name key, all patients that had GOOD located anywhere in their last name would be listed. Such as GOODYEAR or GOODLY or YEARGOOD. If an optional first name key is entered it will operate the same way but both the first and last name key must prove true to be selected.
30 Days
60 Days
90 Days
180 Days
365 Days
Cancel

Patient Acct# <F1> from this field will allow you to look up the patient. *(for more information see page 211)*

Last Name Key and First Name Key – You may do partial name search with the last and first name keys.

30, 60, 90, 180, 365 Days – This is the number of days in the future that the system will search for the appointment.

E-Mail

You can access the inner office E-Mail system from this point in the appointment system. *(for more information see page 295)*

JUMP TO

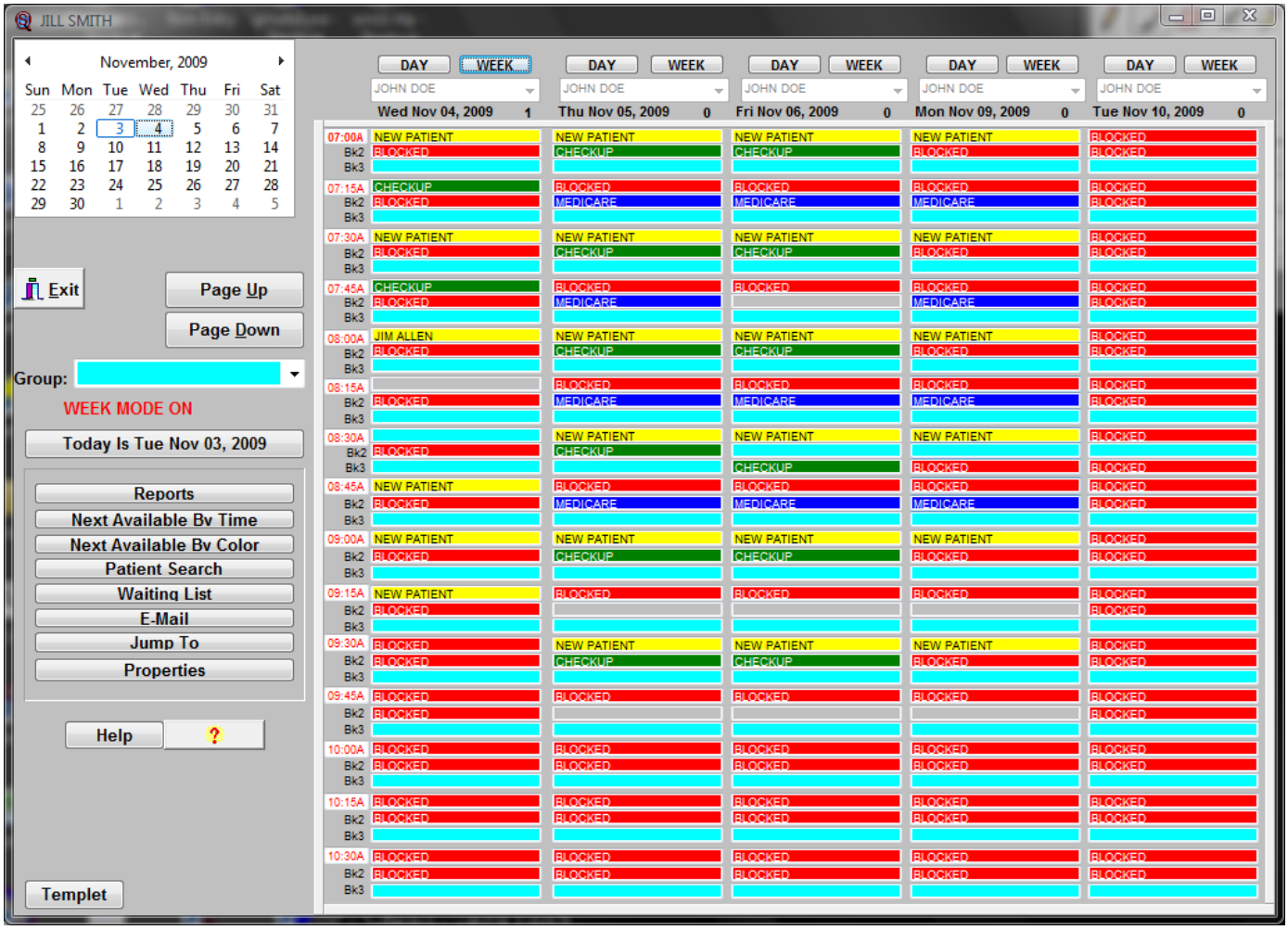
Jump To gives you the ability to jump to a certain date in the future.



TEMPLET

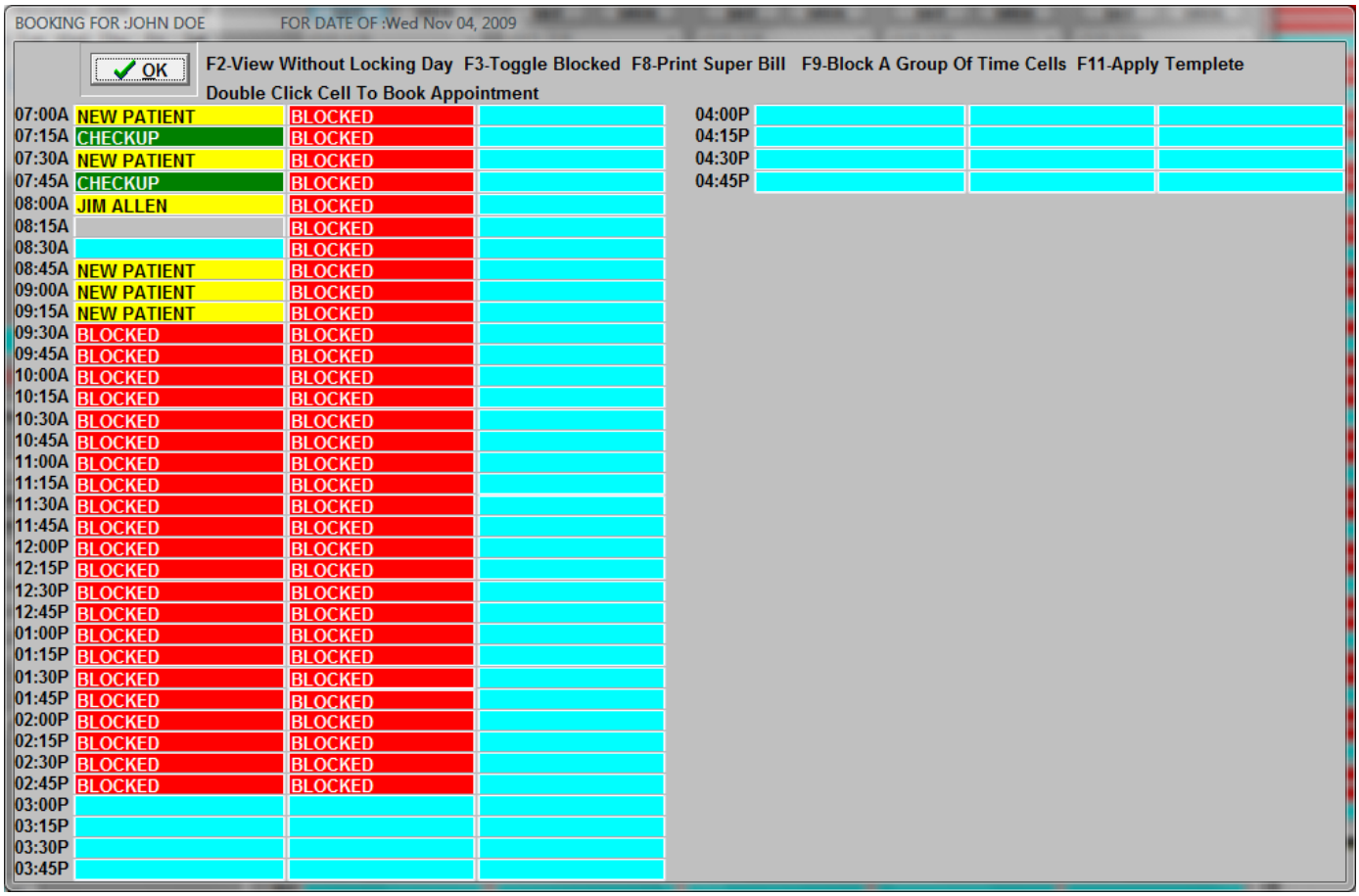
The templet button lets you use the layout of the first appointment book to be saved as a templet.*(for more information see page 119)*

Hi Resolution Appointment Scheduler



The High Resolution version of the multi-view appointment system is design to run on systems that have their monitor set to a resolution of 1024x786 or higher. The section describing the multi-view scheduler applies to this scheduler as well *(for more information see page 124)*.

Day View



Clicking on the “Day” button above each column of the appointment system allows you to get a complete day view for that doctor on a single screen. This screen works like the regular appointment screen and from here you can perform the following actions:

Double Click - Double clicking on a appointment slot will let you book an appointment. Each doctor has three books for each appointment time.

F2 – Pressing **<F2>** while your cursor is in an appointment cell that has an appointment will bring up a screen with the information about the appointment without locking the day for other users.

F3 – Allows you to quickly block or unblock a empty appointment cell under the cursor.

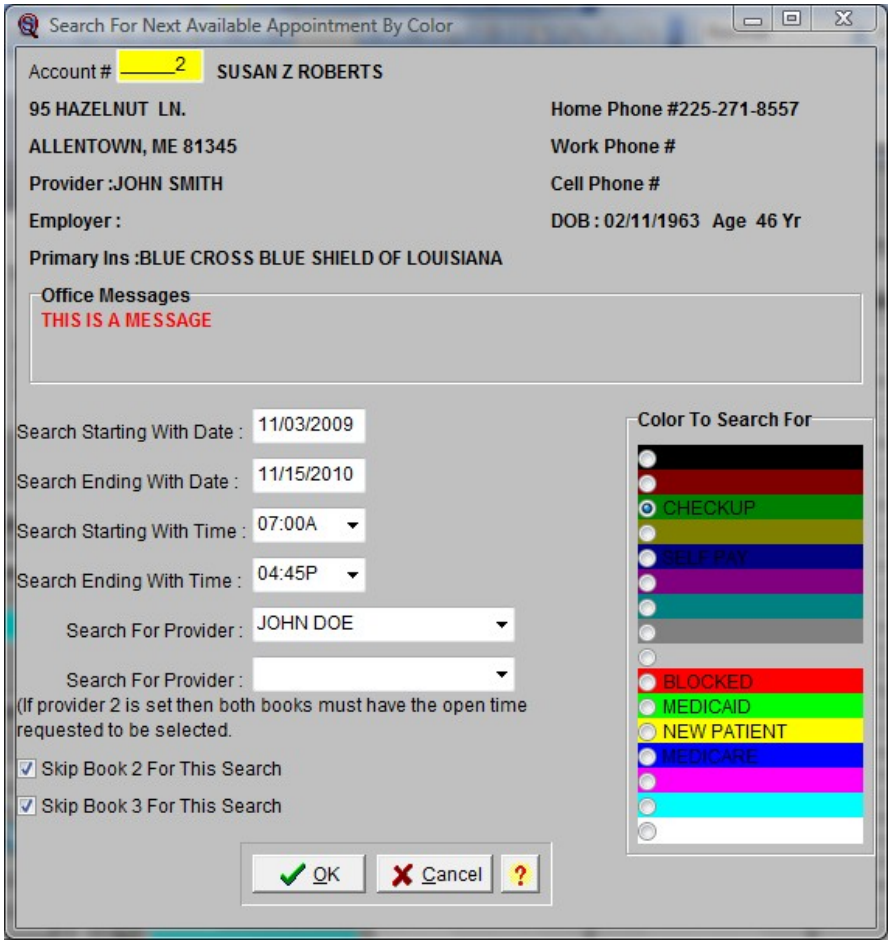
F8 – Will print out a single Super bill for the appointment under the cursor.

F9 – Allows you to block a group of time by setting the block from and block to times.

F11 – Brings up a menu were you can pick a template from any weekday and apply it to the current day.

Next Available by color

This feature allows you to search for the next available appointment time that is defined to a certain color.


Search For Next Available Appointment By Color
Account # 2
SUSAN Z ROBERTS
95 HAZELNUT LN.
ALLENTOWN, ME 81345
Provider :JOHN SMITH
Employer :
Primary Ins :BLUE CROSS BLUE SHIELD OF LOUISIANA
Home Phone #225-271-8557
Work Phone #
Cell Phone #
DOB : 02/11/1963 Age 46 Yr
Office Messages
THIS IS A MESSAGE
Search Starting With Date : 11/03/2009
Search Ending With Date : 11/15/2010
Search Starting With Time : 07:00A
Search Ending With Time : 04:45P
Search For Provider : JOHN DOE
Search For Provider :
(If provider 2 is set then both books must have the open time requested to be selected.
Skip Book 2 For This Search
Skip Book 3 For This Search
OK
Cancel
Color To Search For
CHECKUP
SELF PAY
BLOCKED
MEDICAID
NEW PATIENT
MEDICARE

Account # - If the account number is set a appointment will be created for this patient if a empty time slot is found.

Color to Search For - Only empty appointments that are set to the color that you choose will be accepted.

Search Starting With Date – This is the date that the system will start searching from.

Search Ending With Date – This is the date that the system will search too.

Search Starting With Time – This is the time that the system will start searching from.

Search Ending With Time – This is the time where the system will stop searching.

Search For Provider – If a provider is selected here; the system will search for an available appointment for this provider only.

Search For Provider Two – If a provider is selected here; the appointment system will allow the search to find open times for this provider also.

> **Note:** If provider two is set then both books must have the open time requested to be selected.

WORKING WITH PATIENTS IN QUICK-MD

Quick-MD was designed to allow you to work with your patients in as simple and intuitive a manner possible. Most of the work you will do with your patients will occur in the **Patient Demographics Screen**. This one screen acts as a pivot point from which all the functionality relating to your Patients can be accessed.

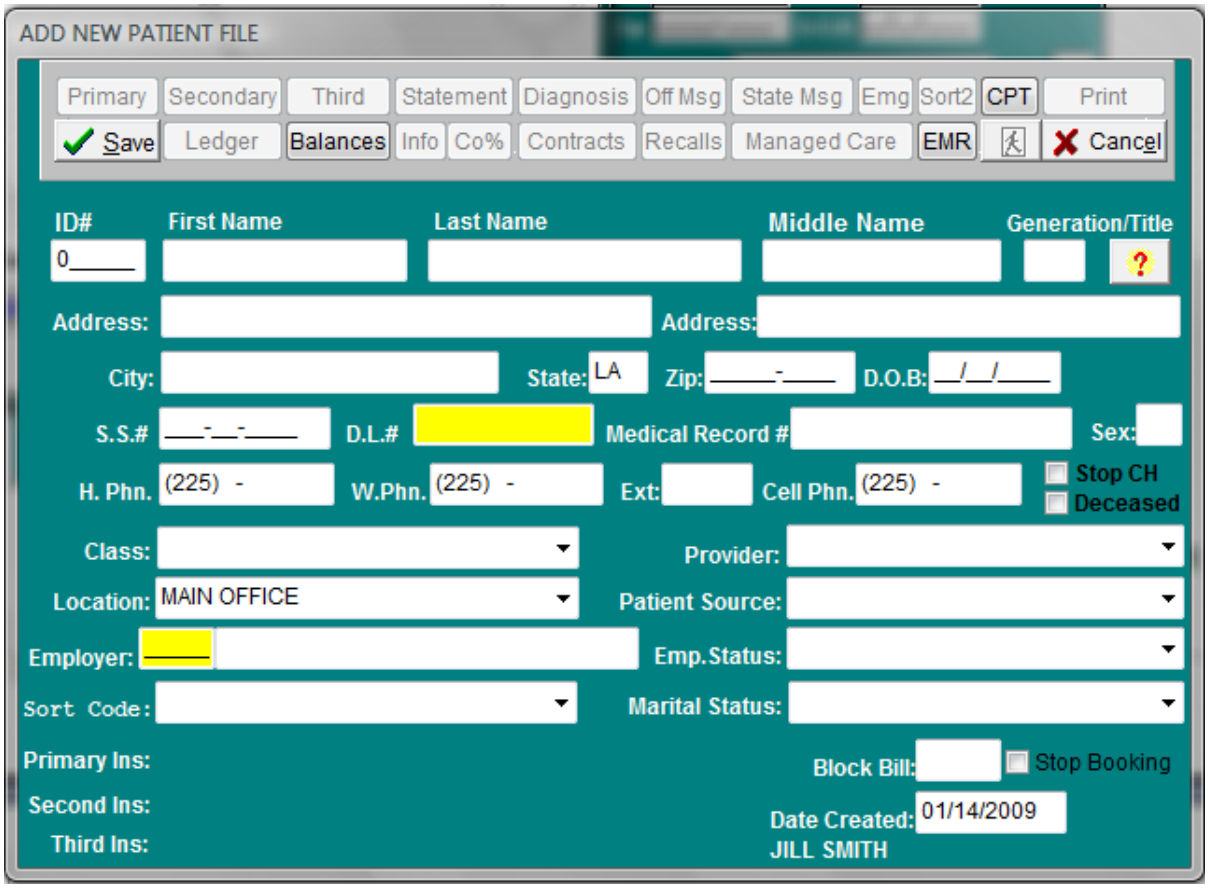
THE FILE MENU

Add a New Patient File

Getting there:



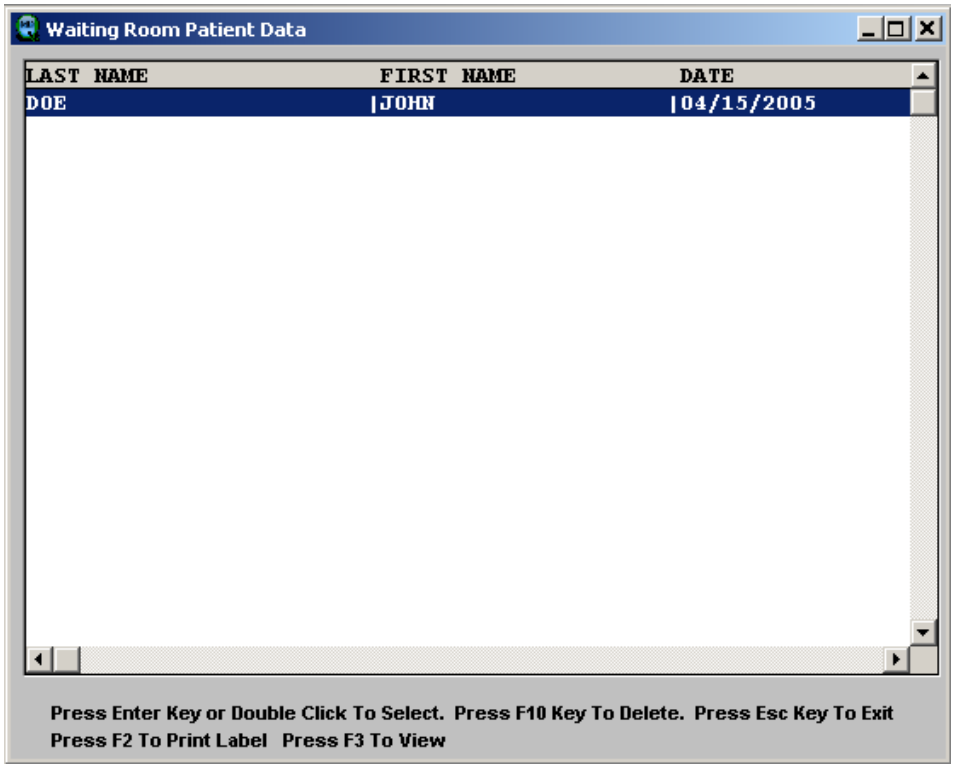
OR click on the  icon.



ID# - To have the system automatically assign the next available ID#, simply press the **Enter** button OR you may enter in your own patient ID#.

FIRST NAME: - Enter Patient's first name.

Pressing **<F1>** in this field will bring up the **Waiting Room Patient Data** browser.


Waiting Room Patient Data
LAST NAME
FIRST NAME
DATE
DOE
JOHN
04/15/2005
Press Enter Key or Double Click To Select. Press F10 Key To Delete. Press Esc Key To Exit
Press F2 To Print Label Press F3 To View

This browser will contain a list of patients that have entered their demographics through the waiting room wizard. Picking a patient from this list will allow Quick-MD to fill out the demographics screen and remove that patient from the waiting room table. Additionally, you can view the patient demographics by pressing **<F3>** or print a label by pressing **<F2>**. The **<F2>** and **<F3>** function keys will not remove the patient from the waiting list. *(for more information see page 297)*

LAST NAME: - Enter Patient's last name.

MIDDLE NAME: - Enter Patient's middle name or middle initial.

GENERATION/TITLE: Enter the patient's generation or title here. I.e. Jr, Sr., etc..

ADDRESS - Enter Patient's address.

ADDRESS - location, Enter a second address, if applicable.

CITY: - Enter the Zip Code and system will automatically fill in city, state and Zip Code (once it has been entered the first time.)

D.O.B: - Enter the Patient's date of birth in a eight digit format (01/01/2000)

S.S.# - Enter the Patient's Social Security number

D.L.# - Enter the Patient's Drivers License number

MEDICAL RECORD - Enter the Patient's clinical number assigned by the facility. This number typically is either a Hospital record number or maybe a Chart number. This number is not to be confused with the Patient ID number. Quick-MD can search for and retrieve a Patient's File by this number.

H.PHN# - Enter the area code and phone number.

W.PHN# - Enter the area code and phone number of Patient's employer.

EXT# - Enter the extension for the work phone number.

CELL PHN# - Enter the patient's area code and cell phone number.

SEX - Enter the letter **M** if the Patient is a male or **F** if the Patient is a female.

(Stop CH) - If you want to stop electronic billings through Clearing House, click the box to put a check mark

(DECEASED) - If the Patient is deceased, click the box to put a check mark to identify the Patient as being deceased

> ***NOTE:*** *All fields that have a down arrow on them: you have the ability to make a selection by entering the number in front of the desired choice and then hitting the enter key, by using the up and down arrow keys to bring in the desired choice and then hitting the enter key, or by using the mouse to click on the arrow and then clicking on the desired choice.*

CLASS - Use the down arrow key to select the Patient's Financial Class. The Financial Class is a table set up by each office for reporting purposes.

> ***NOTE:*** *The **FINANCIAL CLASS TABLE** (for more information see page 69) can store up to 25 financial classes. Typically each office will set up the Government Agencies, the larger Insurance Agencies in their area and group the balance of Insurances under Private or Commercial Insurances. Self-Pay, Workers Comp, and Attorney's (if applicable) would also be included. This table is for reporting purposes ONLY!*

PROVIDER - Use the down arrow key to select the appropriate Provider treating Patient.

> ***NOTE:*** *The **PROVIDER TABLE** (for more information see page 65) can store up to 26 Providers. Also one may be defaulted (**Properties/Patient/Patient defaults**)*
> ***IF YOU ALWAYS WANT THE CHARGES FOR ALL PATIENTS TO SHOW UP UNDER THE PROVIDER SET ON THE DEMOGRAPHIC SCREEN, REGARDLESS OF THE PROVIDER SELECTED DURING THE CHARGE ENTRY, GO TO PROPERTIES/OPTIONS/MISC. Defaults**, and check the box **Use Provider listed in Patient File.***
> *If this box is unchecked, then the Provider selected during the charge entry process will be used on the 1500 form*

LOCATION - Use the down arrow key to select the location Patient receives treatment.

> ***NOTE:*** *The **LOCATION TABLE** (for more information see page 66) can track up to 10 satellite locations.*

EMPLOYER - Enter the name of the Patient's place of employment. You can also use the F1 key to pull over an additional employer or use the F10 to add an employer to the table.

EMP. STATUS - Use the down arrow key to select the Patient's employment status.

> ***NOTE:*** *The **EMPLOYMENT STATUS TABLE** (for more information see page 78) can store up to 10 statuses. This is a HFCA defined Table.*

SORT CODE - Use the down arrow key to select the appropriate sort (reporting code)code to further classify Patient for Reporting and management purposes.

> ***NOTE:*** *The **SORT CODE TABLE** (for more information see page 72) can store up to 99 codes.*

Marital Status - Use the down arrow key to select the marital status of Patient.

*Note: The **Marital Status Table** (for more information see page 77) can store up to 8 statuses.*

Block Bill - Enter the appropriate Responsibility Code below if you do not want to bill this claim:

- P Patient Statement
- I Primary Insurance Billing
- S Secondary Insurance Billing
- A Third Insurance Billing

*Note: There is a **Blocked Bill Report** (for more information see page 281) available that will give a list of all blocked bills.*

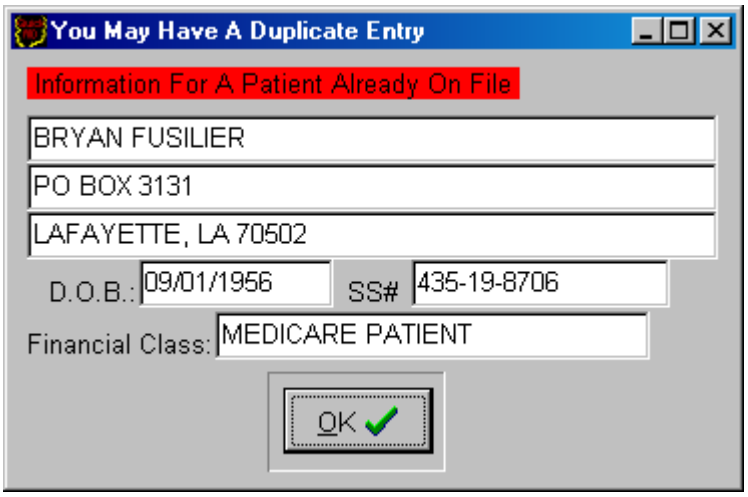
*Note: If you do not want to save the information you inputted then select the **Cancel** button to exit.*

After all fields of entry have been completed, continue to hit the **<Enter>** key and the <***Save***> button will become hot and will allow Quick-MD to assign the next available Patient ID number and to have all of their information stored in system. If you hit the **<Enter>** key again, the primary insurance button will become hot. You always want to setup insurances immediately after setting up the demographics, so the system can auto decide who is responsible for the claim during the charge entry process.

Notes:** After the patient's information has been saved, you can print a label by pressing **<F2>** or **<F3>.

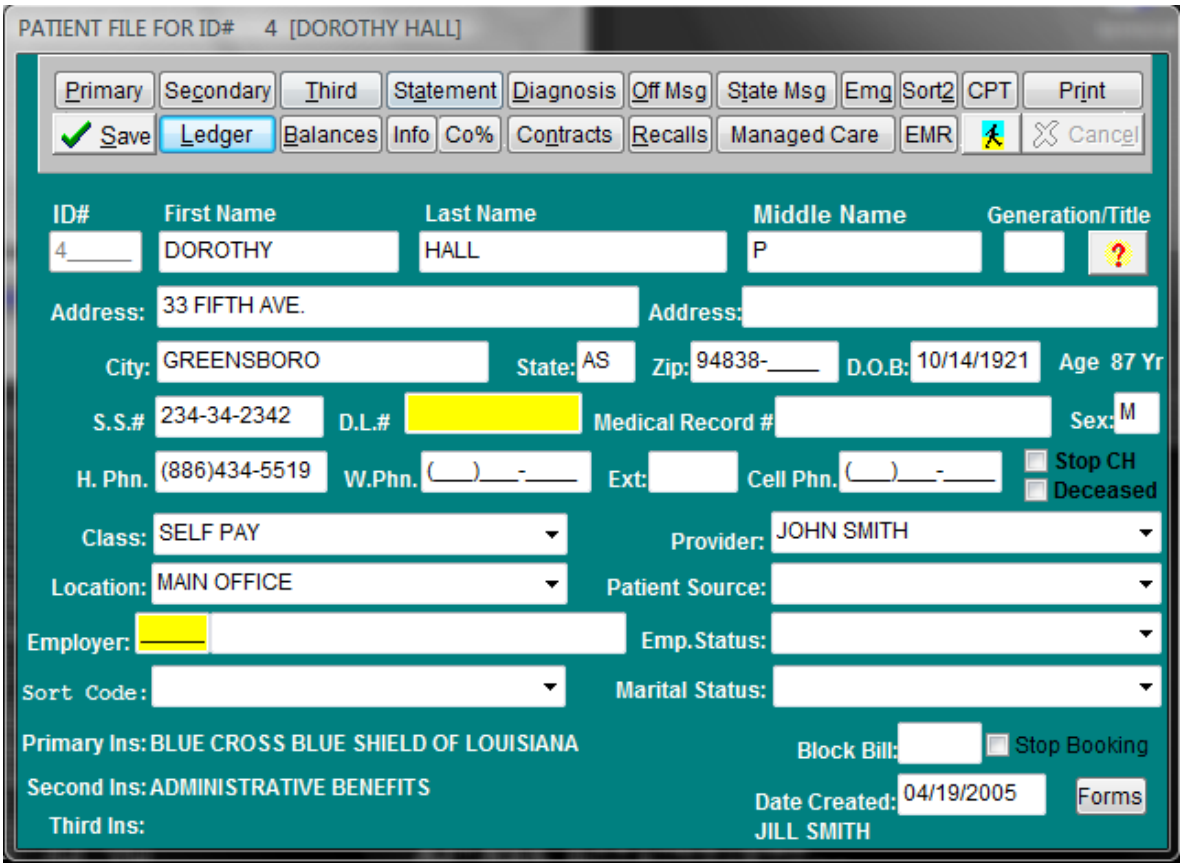
Duplicate Patient Window

Quick-MD will notify you if there is a potential duplicate entry in the system.

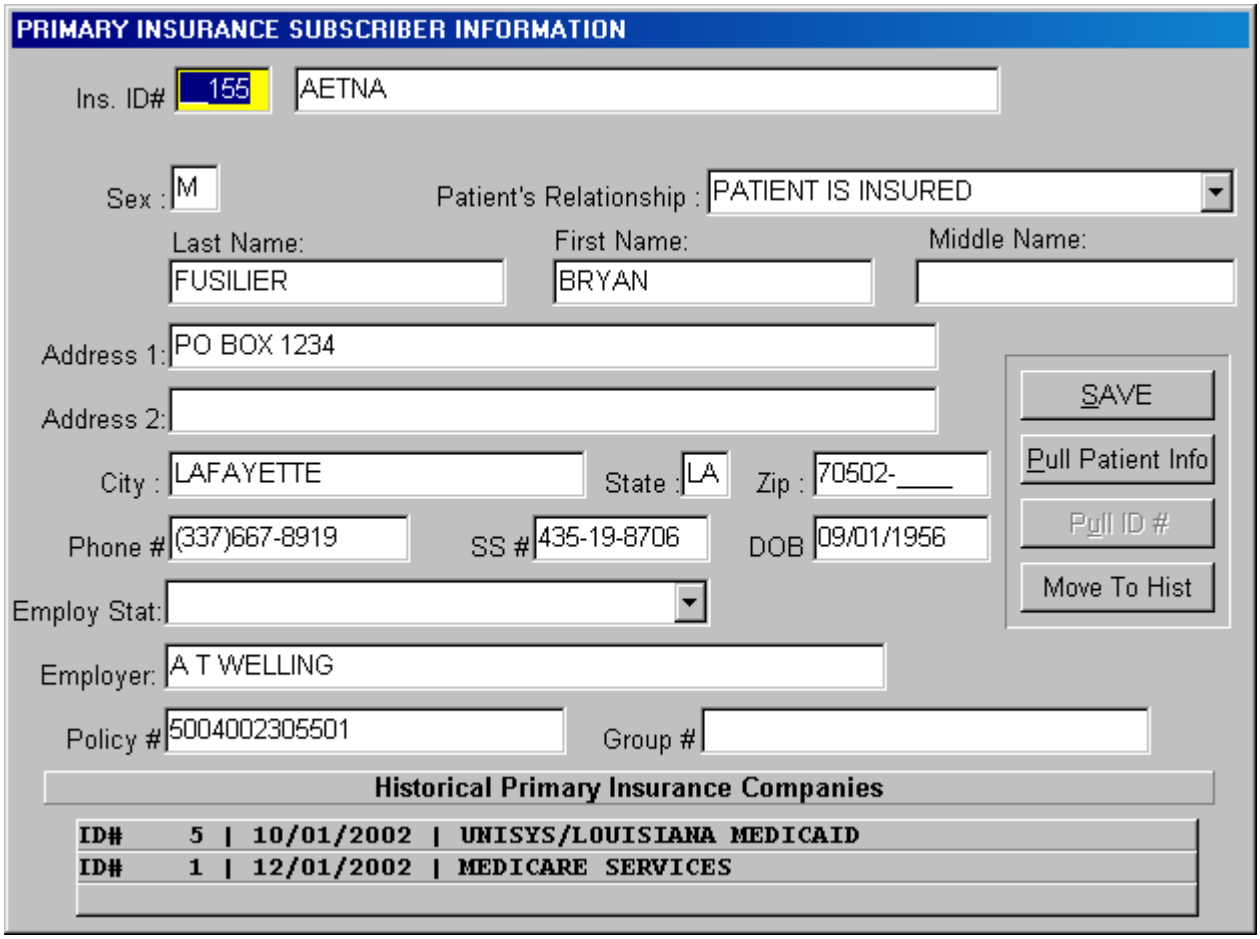


Entering Patients Insurance Information

Once the patient's basic demographics are entered, it is time to setup their insurance information. The first three buttons across the top of the **Patient Demographics Screen** are used for setting up and maintaining the patients **Primary**, **Secondary** and **Third** Insurance Policies.



Always Begin by setting up the patients **Primary** Insurance.



Ins. Id - Enter the Insurance ID number of the Insurance company in your system. To search, press the **<F1>** Key. If the Insurance Company needed is not already in your insurance table, then the **<F10>**key allows you to add it on the fly from here.

> ***Note:*** *If the patient IS the insured, then you are finished. Simply hit the* ***Pull Patient Info*** *button or hit* ***<Alt>+< P>*** *(this the quickest way) and all of the patient's information will be pulled in from the demographics screen. (This feature does not prevent you from copying the information and then editing certain fields. An example of when this would be used is when the patient is the child and the parent is the insured. You can pull the patient info and then most likely change the first name and the social security number.)*

Patient's Relationship – Select the Patient's relationship to person the insurance policy belongs to. These values are setup by you in the **Patient Relationship Table** *(for more information see page 78)and are HCFA defined.*

Sex - Enter the appropriate sex of the insured party. Enter M if the insured is a male. Enter F if the insured is a female.

L.N. – Enter Last name

F.N. – Enter First Name.

M.N. – Enter Middle Name.

Address - Enter the address where the Insured resides

Address 2 - Enter a second address if applicable

CITY - Enter the city where the Insured resides-or you may enter in the **ZIP CODE** here and Quick-MD will automatically fill out the city, state and zip for you.

STATE - Enter the abbreviation of the state where Insured resides.

ZIP -Enter the Zip Code where the Insured resides

PHONE - Enter the area code and phone number of the Insured

SS# - Enter the social security number

DOB - Enter the date of birth of the Insured

EMP. STAT - Use the down arrow key to select the employment status of the Insured.

> ***NOTE:*** *The* ***EMPLOYMENT STATUS TABLE*** *(for more information see page 78) can store up to 10 statuses.*

EMPLOYER NAME - Enter the name of the Employer.

HCFA POL# - Enter the policy number of the Insured from the Insurance Medical Card. If the Policy number is the person's social security number' then enter **SS** and press the **<ENTER>** button, this allows Quick-MD to put Patient's social security number in HCFA policy number field.

> ***NOTE:*** *If the Policyholder is the patient, and his/her Social Security is their policy number, then Typing* ***SS*** *in this field will automatically pull the patients Social Security number from the Patient Demographic Screen.*

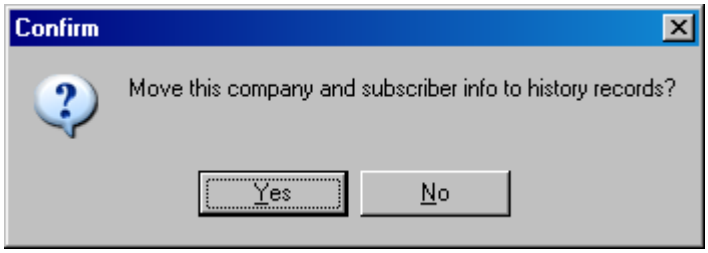
HCFA GROUP# - Enter the group number of the Insured from the Insurance Medical Card.
Quick-MD allows users to track up to four different primary insurances. These insurances can be manually chosen when entering charges or you can allow Quick-MD to auto decide which primary insurance based on date ranges.

> ***NOTE:*** *The setting to turn the "auto decide" on is found in* ***MISCELLANEOUS DEFAULTS*** *(for more information see page 91).*

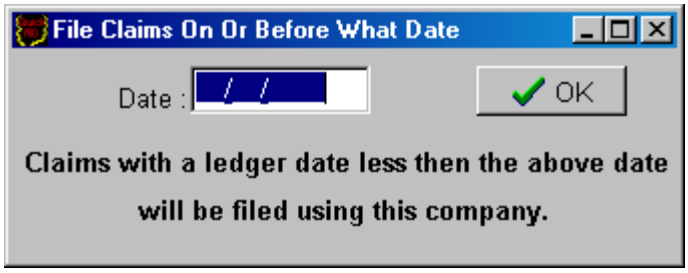
HISTORICAL PRIMARY INSURANCE COMPANIES:

This feature allows users to move insurances to history, by clicking on the "Move to History" button and then view primary insurances assigned to history by clicking on the appropriate insurance in history. Quick-MD will automatically bill the proper insurance, based on the date of service and the date entered when moving to history.

The **MOVE TO HISTORY** button allows users to move patients current primary insurance to history.



Enter an ending date that Quick-MD will utilize as the last date of service to file this insurance as primary unless re-billing an older claim. Click **<OK>**

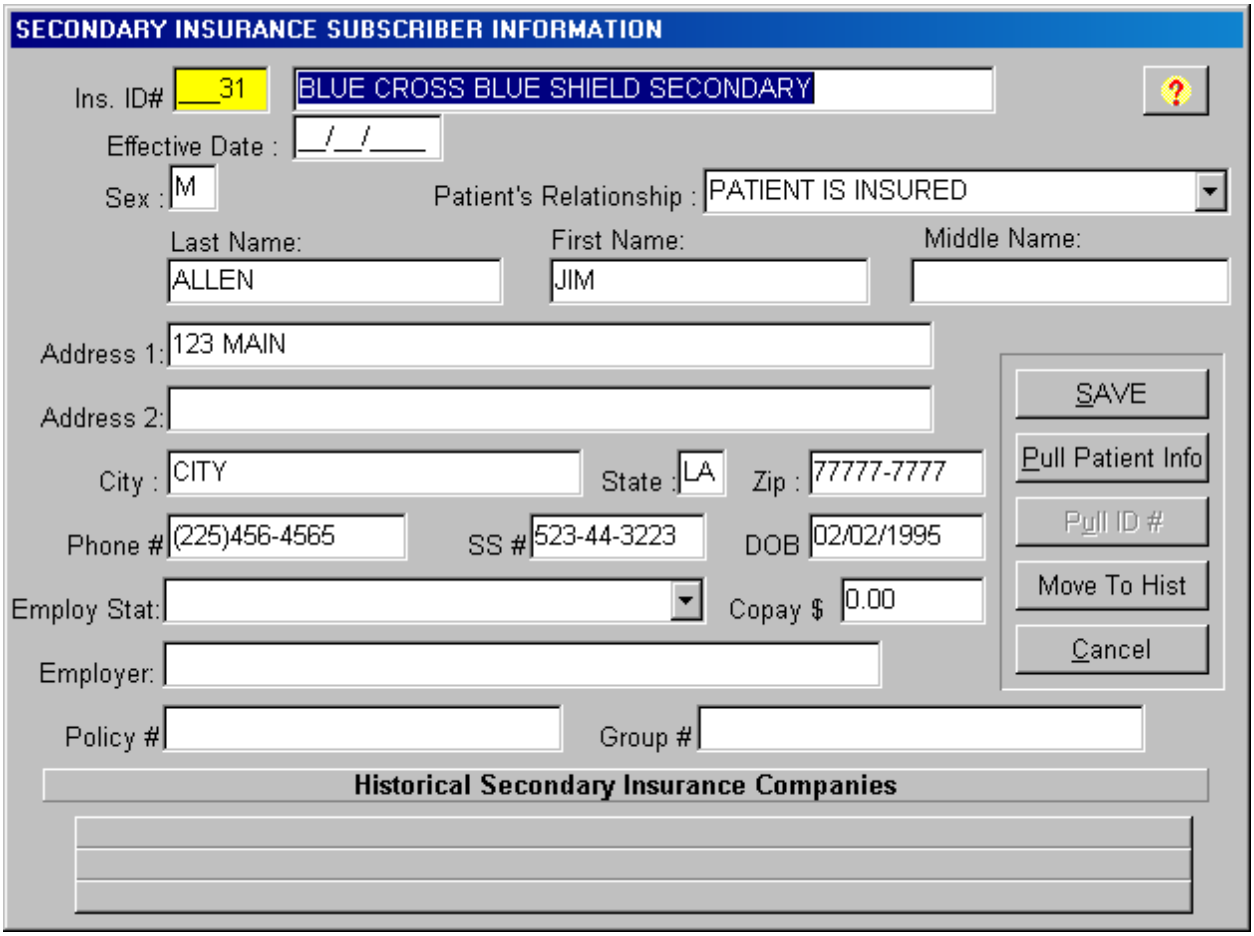

File Claims On Or Before What Date
Date :
OK
Claims with a ledger date less then the above date
will be filed using this company.

After all fields of entry have been completed, select the **SAVE** button to allow Quick-MD to save Insurance Subscriber Information to the Patient's account

SECONDARY INSURANCE

Use this feature to setup the patient's secondary insurance information. Aside from the effective date, this information is setup exactly like the Primary.

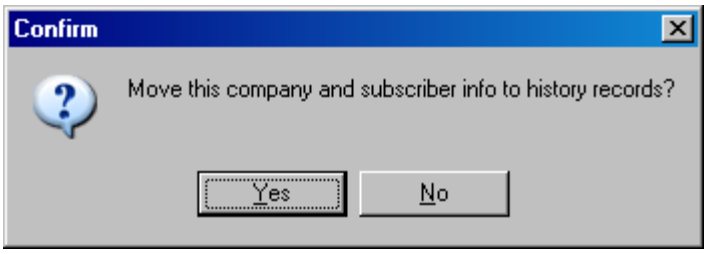
The effective date will appear on all quick payment posting modules. When re-assigning claims to Secondary or Third from the payment posting modules it is the operators responsibility to check these dates before re-assigning. When working inside the patient's ledger where the operator cannot see the effective date, the system will check them for you when you re-assign a claim. If a date of service on the claims is before the effective date a warning message will appear.



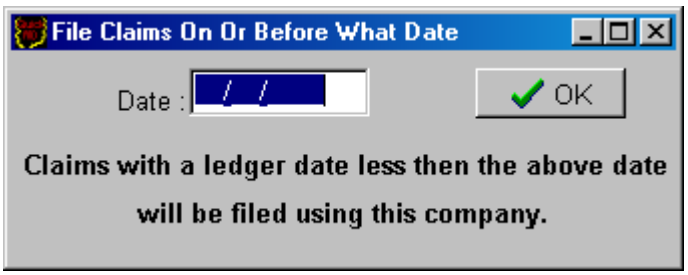
***NOTE:** When Quick-MD sees that Medicaid is secondary to a private insurance, the group number field will automatically be changed to the TPL number and will print in block 9A on the HCFA 1500 form.*

HISTORICAL SECONDARY INSURANCE COMPANIES:
This feature allows users to move insurances to history, by clicking on the “Move to History” button and then view primary insurances assigned to history by clicking on the appropriate insurance in history. Quick-MD will automatically bill the proper insurance, based on the date of service and the date entered when moving to history.

The **MOVE TO HISTORY** button allows users to move patients current primary insurance to history.



Enter an ending date that Quick-MD will utilize as the last date of service to file this insurance as primary unless re-billing an older claim. Click **<OK>**

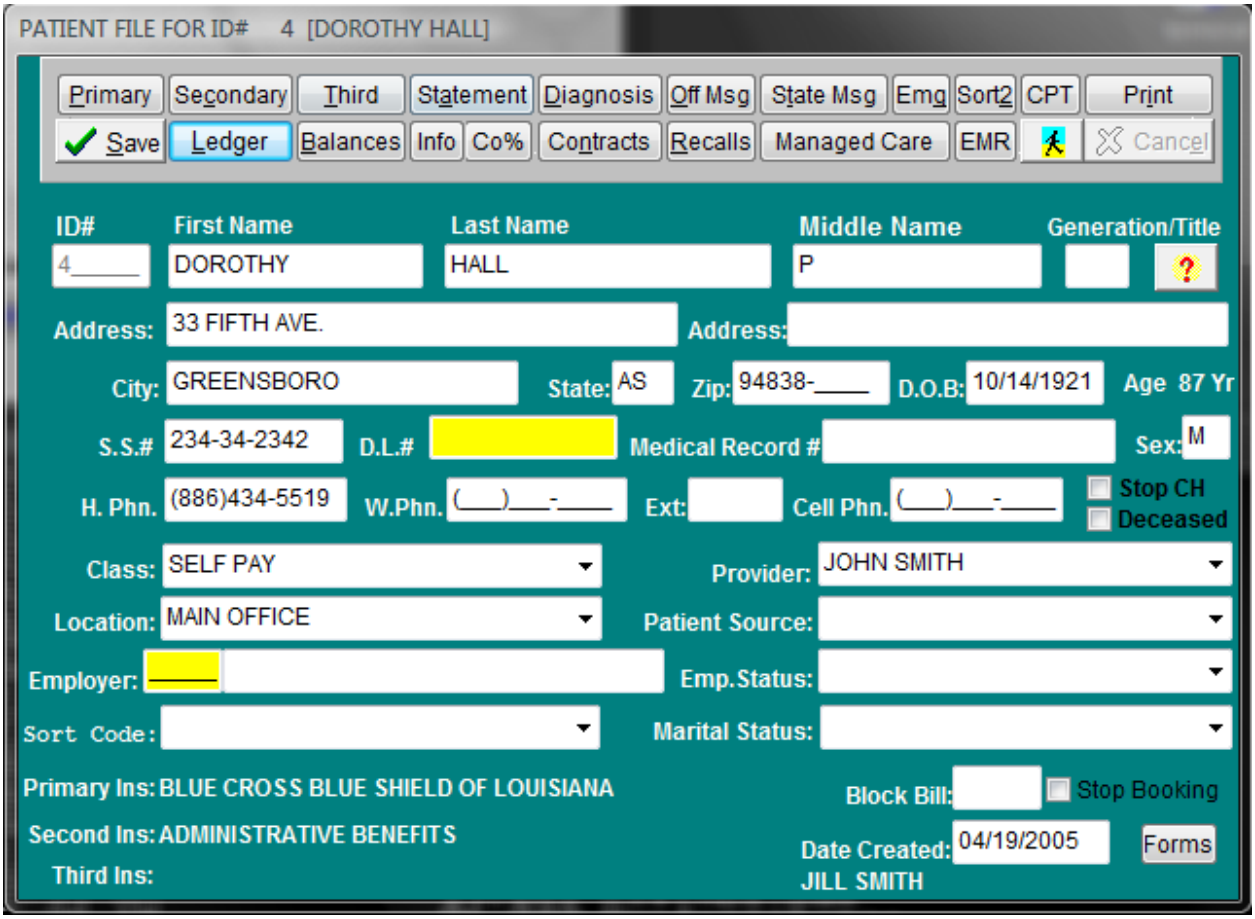

File Claims On Or Before What Date
Date :
OK
Claims with a ledger date less then the above date
will be filed using this company.

After all fields of entry have been completed, select the **SAVE** button to allow Quick-MD to save Insurance Subscriber Information to the Patient’s account

THIRD INSURANCE
Use this feature to setup the patient’s Third insurance information. This information is setup exactly like the Secondary.

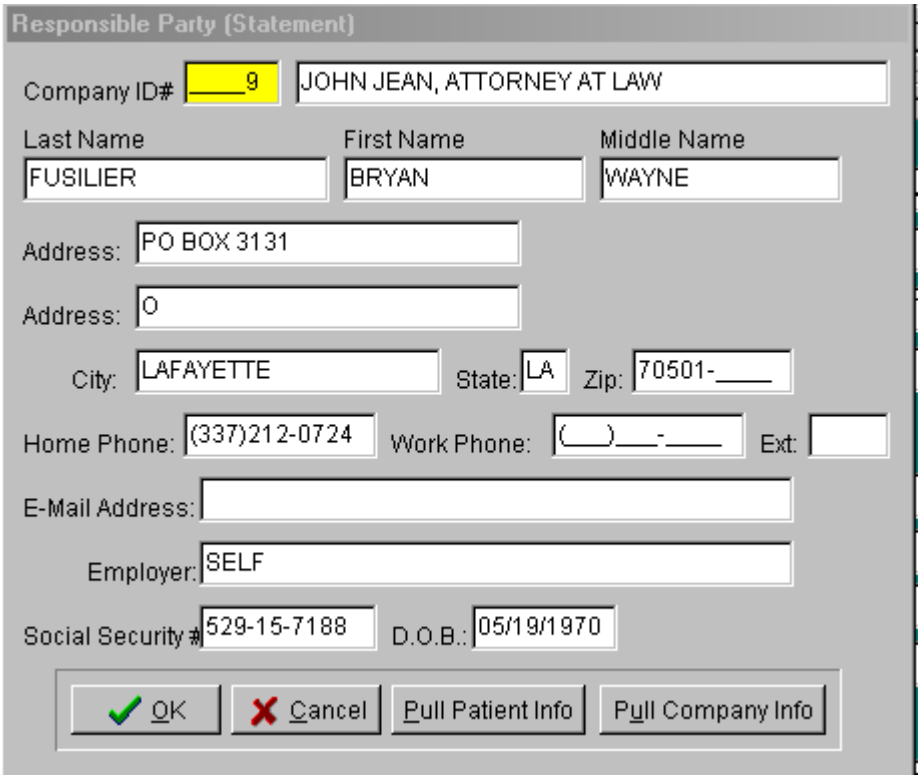
Other Features of the Patient Demographics Screen

In addition to the patient demographics and insurance information, the Patient Demographic screen gives you access to a wealth of other important information. We will now take a look at each of these in turn.



[Statement] - Patient Statement Information

The statement field is used when the guarantor is not the same person or does not have the same address as the patient on the demographics screen. *(If the guarantor is also a patient and has children who are patients, see* ***Dependants*** *on page 180)* If a patient statement goes to somewhere other than the address on the main demographic screen, then Quick-MD will send the statement to the person and address in the statement box.

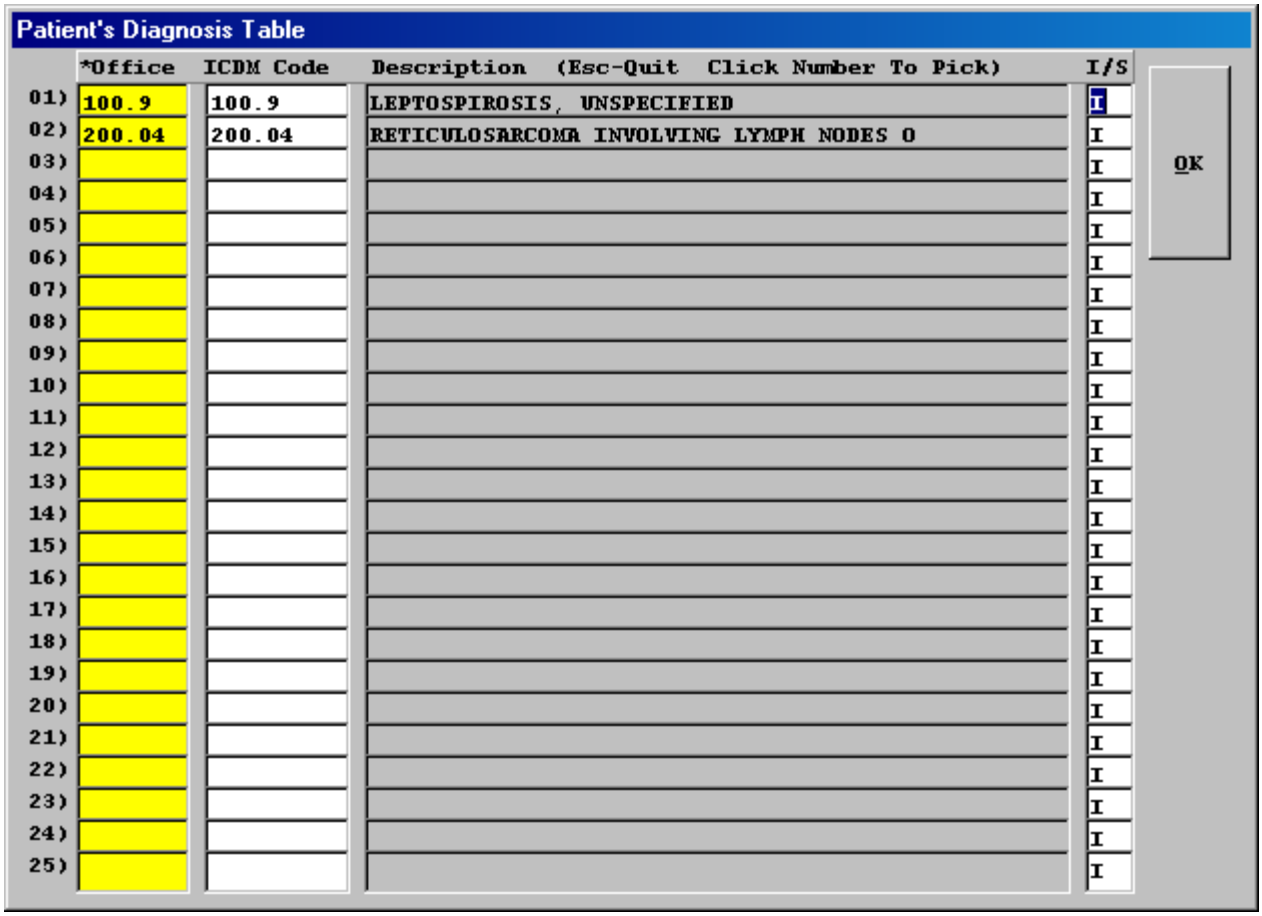


Note: *If the patient is the guarantor of the account, or the bill goes to the address on the demographic screen, then you do not need to re-enter their information here. This is only filled out when the patient statement goes somewhere besides the address on the demographic screen!*

Note: *To send the statement to a company or an attorney, that is set up in the system, hit* ***F1*** *in the yellow field, (or hit* ***F10*** *and add them) pull them in by ID# and then hit the button* ***Pull ID#****. This feature will pull in the appropriate billing address. A prime example of this is in an injury case. The statement would go to an attorney instead of the patient or insured. If this occurs on a regular basis, you can add that attorney information in the insurance table and then access it this way instead of typing the same information every time. This would also apply to billing Companies.*

[Diagnosis] - Patient Diagnoses Table

The patient's diagnosis table is used to store this patients last 25 diagnosis. This screen is normally populated over time while performing the **Charge Entry Process,** but you are free to populate it or review it at anytime. This table is not only available from the patient's main demographic screen, but is also used during the charge entry process and is available from within the patients ledger, by highlighting a charge and hitting F4 to edit, then from the first yellow pointer field, hitting **F1**.

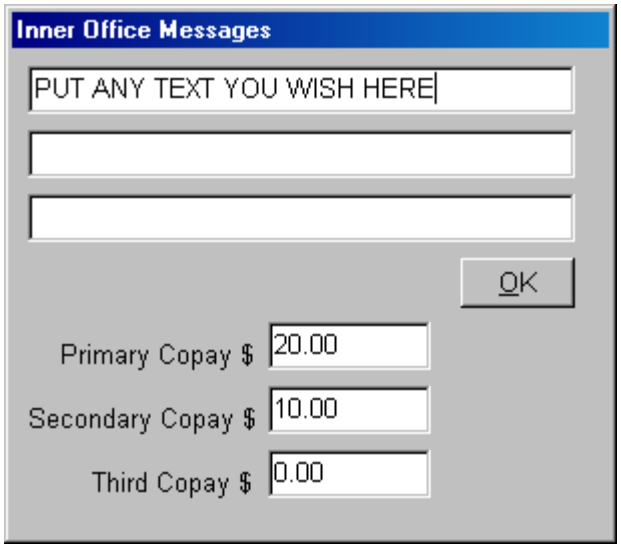


Diagnosis records are added to the patient's diagnosis table by typing the diagnosis code in, or from the master diagnosis table by using the **<F1>** key in the yellow field to browse. The **<F10>** KEY from the yellow field allows you to add a record in the master diagnosis table on the fly.

The I/S column allows the user to define individual diagnoses as isolated (I) or standing (S). If standing is chosen, Quick-MD will automatically attach those diagnoses to each charge entered for this patient. If isolated is chosen, the user will manually choose which diagnoses to attach to each charge.

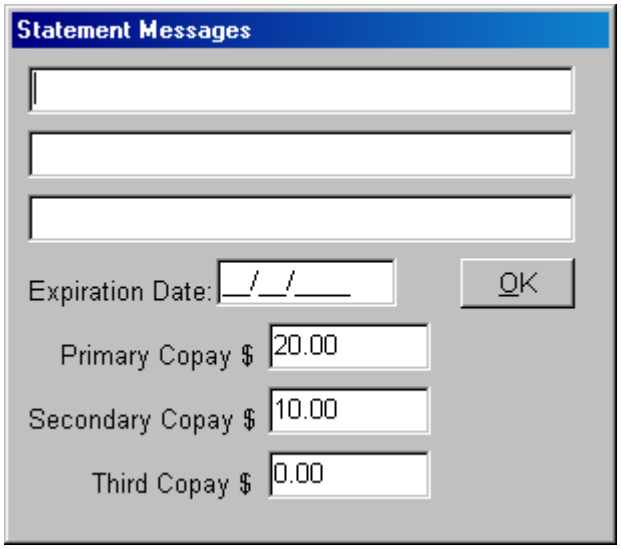
[!OFF MSG] - INNER OFFICE MESSAGES

This feature allows you to enter notes you want attached to a Patient File. The message box will appear each time you open this Patient File if it has something in it.



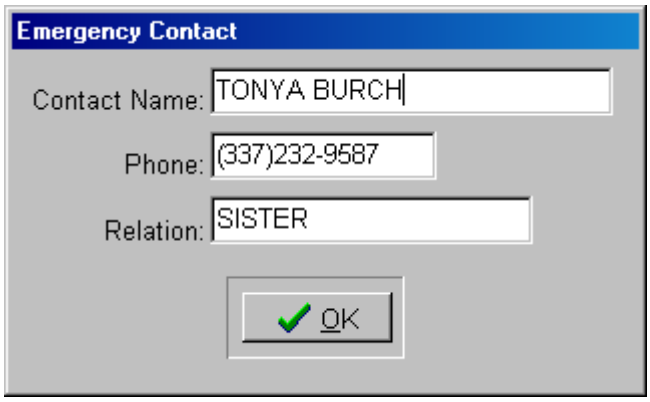
NOTE: *if you have that feature turned on in* ***Settings,*** *in the* ***Enhanced Scheduler****, it will also appear when you choose that patient when scheduling an appointment.*

[STATE MSG] - STATEMENT MESSAGE BOX



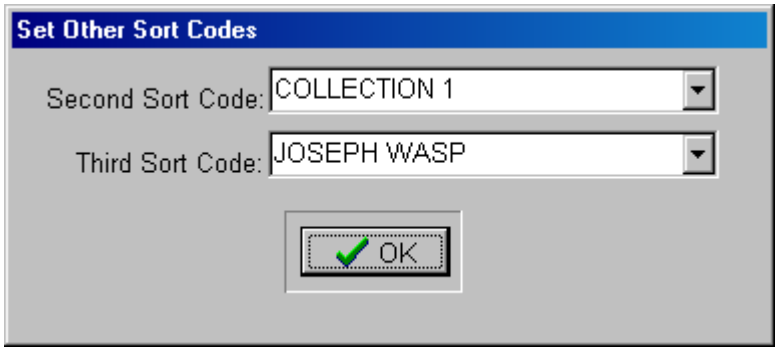
This feature allows you to enter notes you want included on the Patient Statements. When a statement is printed this message will appear on the Patient's Statement indefinitely unless you enter an expiration date. These coordinates have to be set in **Properties/Printed Forms/Patient statement settings.** *(for more information see page 87)*

[EMG] - EMERGENCY CONTACT



This feature allows the user to input an emergency contract person's name, phone number and their relation to the patient in the Patient File.

[SOFT 2] - OTHER SORT CODES _



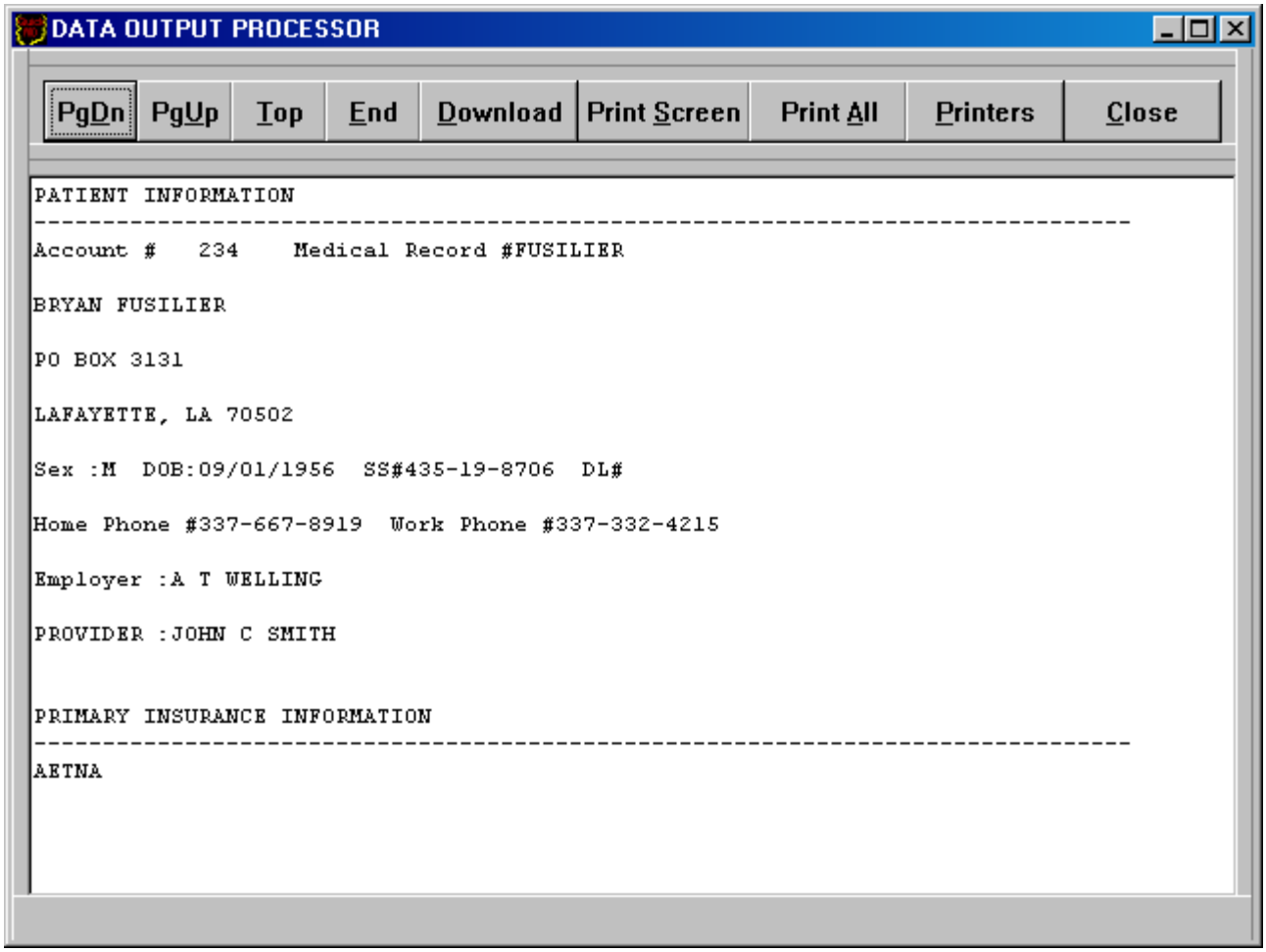
This feature allows the user to select a **SECOND** and **THIRD SORT CODE** to further classify a patient for reporting and business management purposes. Use the down arrow key to select the appropriate Sort Code.

***NOTE:** To use this feature, the **SORT CODE TABLE** (for more information see page 72) must be populated with a listing of reporting codes selected by the user.*

STOP BOOKING
This feature will keep this patient from being booked in the appointment system.

PRINT
Use this feature to print a copy of the patient demographics to be placed in your charts. Clicking the **<PRINT>** button brings up the **DATA OUTPUT PROCESSOR.**

DATA OUTPUT PROCESSOR
The **DATA OUTPUT PROCESSOR** is a window that you will see over and over again in Quick-MD so it is important to become familiar with how it operates. All reports and print jobs in the system are first sent to the **DATA OUTPUT PROCESSOR** where the information can be viewed, downloaded or sent to a printer.

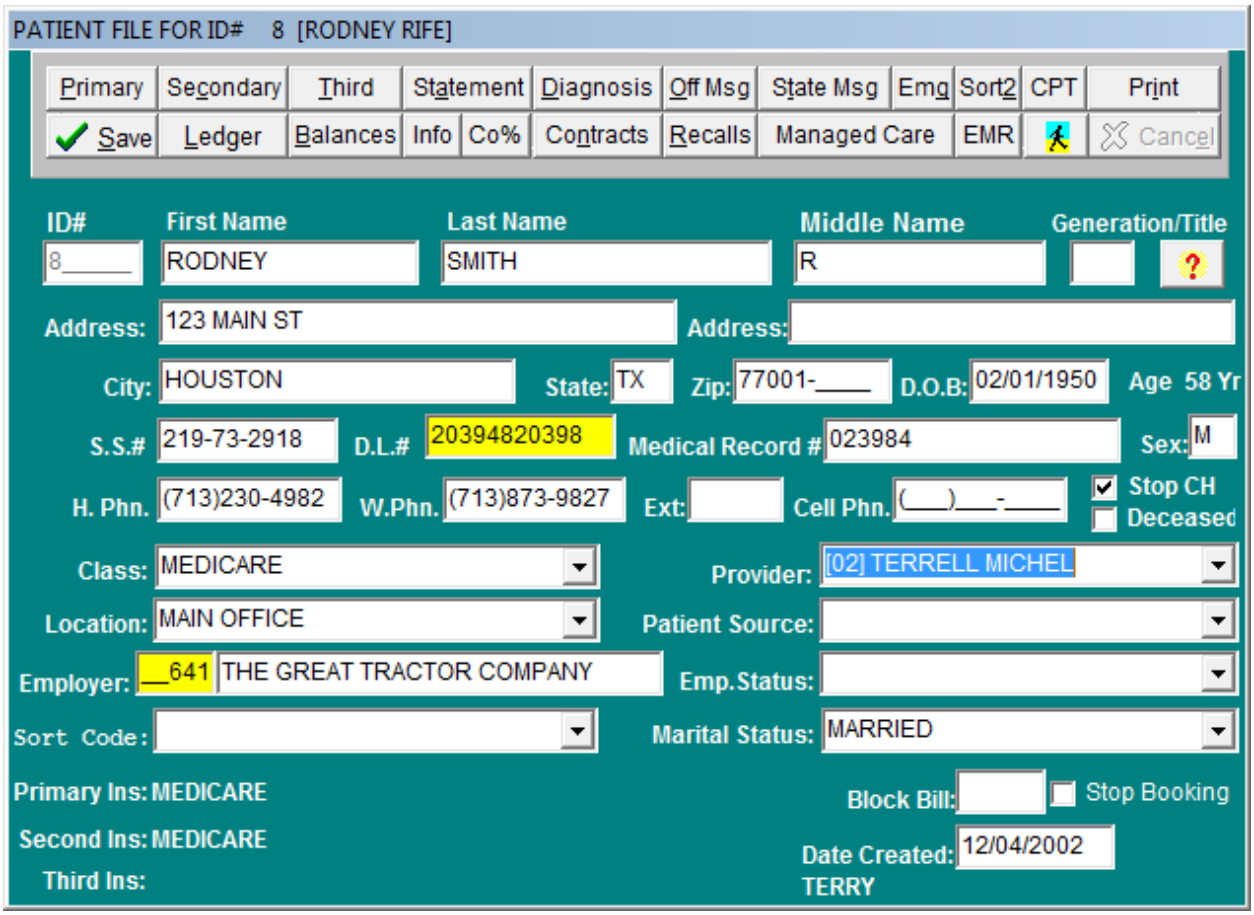


<PgDn> – Scrolls the **Data Processor Output** display forward to the next page of information.
<PgUp> – Scrolls the **Data Processor Output** display backwards to the previous page of information.
<Top> – Scrolls the **Data Processor Output** display backwards to the top of the report.
<End> – Scrolls the **Data Processor Output** display forwards to the end of the report.
<Download> – Saves the output of the Data Processor to a text or pdf file. Select a path to where you want the file to go and select a name that you wish to call it. If you change the "Save as type" to pdf the report will be exported in an Adobe pdf, version 4 and above, format.
<Print Screen> – Sends all the information visible on the screen to the printer.
<Print All> – Sends the entire report to the printer.
<Printers> – Select and configure the printer you will be sending the report to.
<Close> – Exits the **Data Processor Output** Screen.

> ***Note:*** *If the report is too wide to be fully displayed in the window, placing your cursor on the double dotted line and clicking, then using your END and HOME key will allow you to move the processor window back and forth.*

[Ledger] - The Ledger

The **<Ledger>** button accesses the heart of the Quick-MD billing system. It is where all Patient Claims, Charges, Payments and Adjustments are created and maintained.



Patient Ledger

This menu is your springboard for interacting with the Ledger. This allows you to quickly jump into the ledger itself. We will now discuss each option in detail.



Enter Charges New Claim

Use this feature to create a new claim in the patient's ledger. If the patient has insurance setup, then this claim will automatically be assigned the **I** responsibility. If the patient does not have insurance setup, then the claim will be assigned the **P** responsibility.

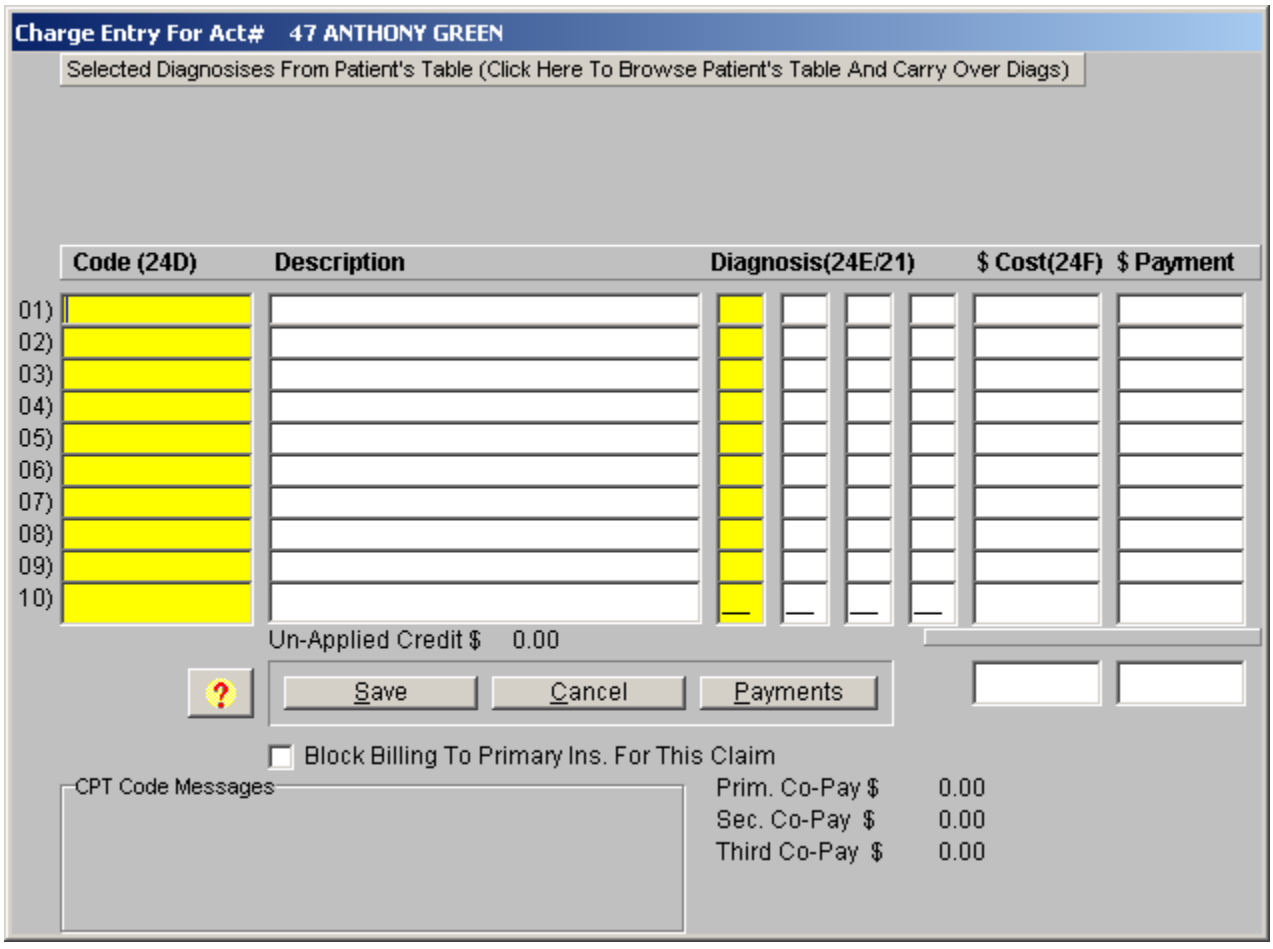
> ***Note:*** *IF you do not understand the Responsibility Codes at this point, you need to stop and learn them as you can not use the system properly without knowing this concept. To learn about Responsibility Codes see page 26)*

Entering charges on a new claim is done through the **Charge Entry Screen**. This powerful tool is tied to various other features throughout Quick-MD in such a way that you can easily enter all information necessary to complete a HCFA 1500 form in the shortest amount of time and with the fewest amount of keystrokes possible. Once you master the use of this screen, you will be amazed at the speed in which you can create accurate claims in Quick-MD.

Charge Entry Screen

Use this feature to enter line item charges for procedures performed at your practice. The overall concept is to enter the appropriate CPT Code, attach the corresponding diagnosis codes and post any payments or use Un-Applied Credits against this procedure.

The proper use of this screen is essential for accurate claim creation, so we will walk you through the entire process step-by-step.



> ***Note:*** *If you check "Block Billing To Primary Ins. For This Claim" then the system will not bill this claim. Also, the number in parenthesis behind code, diagnosis and cost corresponds to the block number of these fields on the HCFA 1500 form.*

STEP ONE: ENTER THE CPT CODE

***CODE –** Enter the Office Code here.

***NOTE**: If you don't know the procedure code, the **<F1>** key allows you to browse the table. You will then have the option to browse by house code, CPT code or by description. These defaults are set up in **BROWSER DEFAULTS** in the **PROPERTIES** menu. (for more information see page 76).*

***NOTE:** If you want to have the option of entering the CPT code instead of the Office Code, you can turn this option on. (for more information, see **Properties/CPT ENTRY OPTIONS** on page 80) But realize that if you have the same CPT code setup multiple times, ie. With different places of service and/or different pricing, each with different house codes, then the first CPT record that matches will be brought in. In these cases you should browse by House Code, or simply enter the house code, to ensure that the appropriate CPT record is called in.*

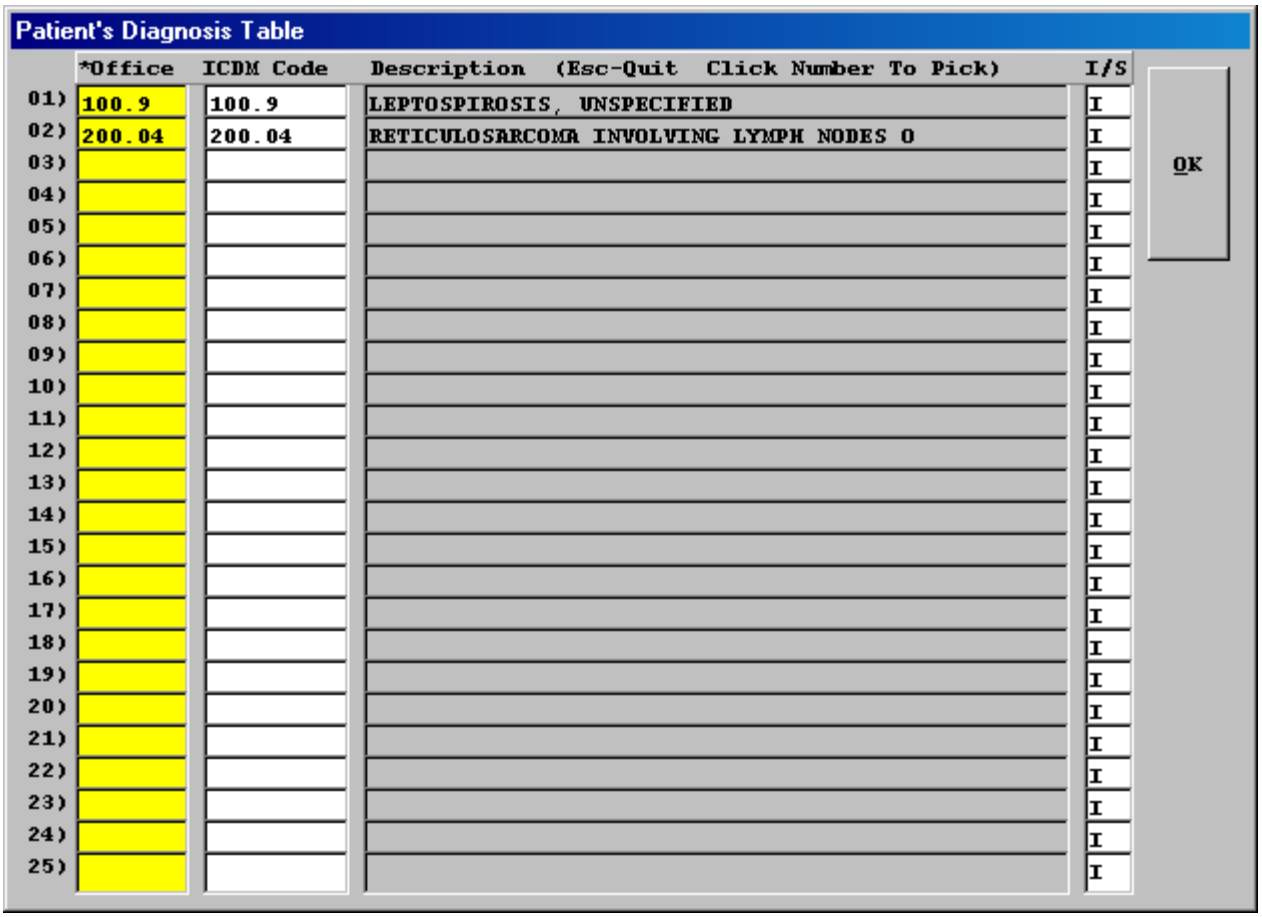
DESCRIPTION – The description is automatically entered once you have selected a code. It comes over as a default from the master CPT record.

STEP TWO: ENTER THE DIAGNOSIS CODE(S)

Your cursor is now in the first yellow **DIAGNOSIS** pointer field. Here you will attach up to 4 diagnosis codes (the max amount set by HCFA) to your procedure code by pointing to the appropriate records in the **PATIENT DIAGNOSIS TABLE** *(for more information see page 157)*.

***Note:** You can also access the patient's diagnosis table by clicking on the button at the top of the form.*

DIAGNOSIS –FROM THE FIRST YELLOW POINTER FIELD, Hit **<F1>** to open the **PATIENTS DIAGNOSIS TABLE.**



If this table has the desired entries in it already, then select the appropriate code or codes (you can select up to four codes at once!) by clicking on the number at the left hand side of the screen (this will turn them green) that corresponds to the diagnosis codes that you wish to apply to this charge. Clicking **<OK>** will then fill in your diagnosis pointers for you. Or you may hit the escape key and simply type the appropriate number(s) in the pointer field.

If the diagnosis code you need isn't there, you can add it to this table by hitting the **<F1>** key and browsing the master diagnosis table or by simply typing in the ICD9 number. If the one you need is not in the master table, then you may add it on the fly by hitting the F10 key.*(you can customize which field your cursor defaults to in Browser Defaults in Properties. For more information see page 76.)*

Once your diagnosis codes are entered into the Patient's table, you can **select** them by clicking on the number at the left hand side of the screen that corresponds to the diagnosis codes that you wish to apply to this charge. Clicking **<OK>** will then fill in your diagnosis pointers for you in the charge entry screen. Or you may hit the escape key and simply type the appropriate number(s) in the pointer field.

> ***NOTE:** It is this procedure of adding to and selecting from this table that ensures that the **PATIENT DIAGNOSIS TABLE** always contains the 25 most recent diagnosis codes used for this patient.*

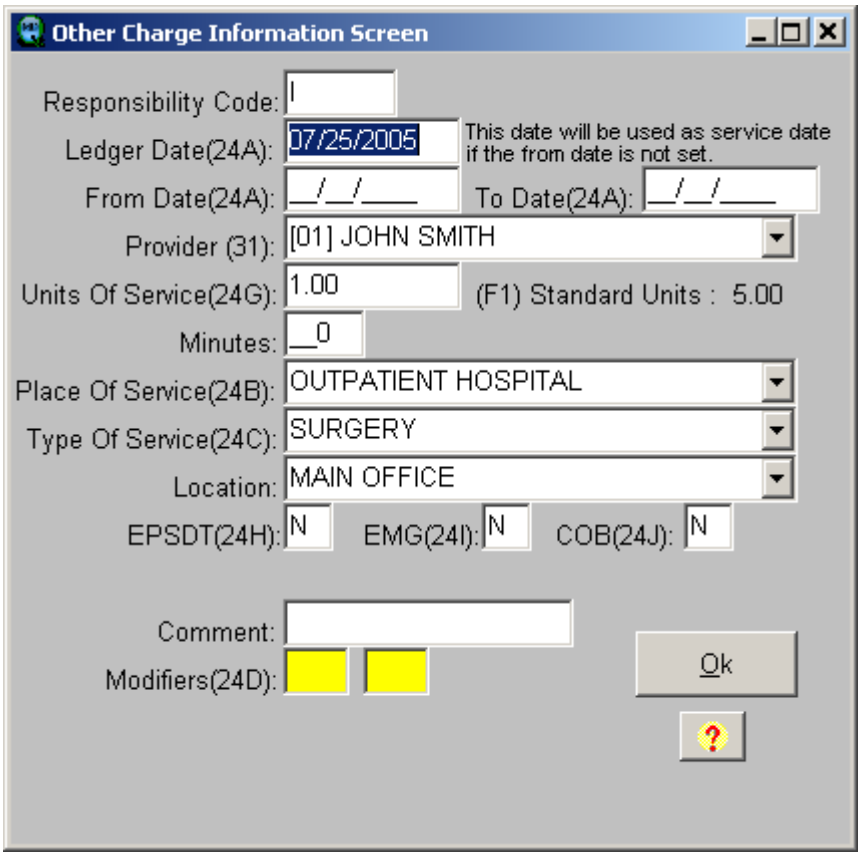
In the I/S column, if the diagnosis is labeled "S" for standing, Quick-MD will automatically insert that diagnosis into the charge screen every time a charge is entered. Any diagnosis labeled "I" for isolated will not be automatically inserted.

STEP THREE: THE OTHER CHARGE INFORMATION SCREEN

You have now filled in the appropriate Diagnosis Pointers and your cursor is sitting in the last diagnosis field used. Hit **<ENTER>** to advance the cursor. When Quick-MD sees an empty diagnosis pointer field, the next time the enter button is hit, the **Other Charge Information Screen** will be displayed.

OTHER CHARGE INFORMATION SCREEN

Use this feature to input all of the information required on the HCFA 1500 that relates to this line item charge.



Note: *The number in parenthesis behind the field descriptions corresponds to the block number of these fields on the HCFA 1500 form.*

Be sure that the Responsibility Code is correct!! For example, if the first entity to be billed is the primary insurance, then the responsibility code needs to be **I**. If you only wanted to bill the patient for this charge, then put a **P** in the field. If Insurance information has been entered for this patient, and you are entering **Charges New Claim**, Quick-MD will automatically assign (**I**) for Primary Insurance responsibility to the claim. If no insurance is setup, then the (**P)** responsibility will be assigned. If you are entering charges using **Enter Charges Patient Claim**, then the **(P)** responsibility will be applied to this claim, regardless if the patient has insurance.

> ***Note:*** *To speed up data entry, isolate the fields on this form that your practice regularly deals with. Configure Quick-MD's cursor to only jump to these fields when moving through the form with the Enter key. (for more information see page 80)*

Ledger Date – If entering from the **fast charge entry screen,** this will default to current date, but it can be changed. This is the Ledger Date and will be used for recap reporting.

From and to Dates -If left blank, will use the ledger date as the date of service, but the user can enter in the appropriate dates of service if other than the ledger date.

Provider - defaults to Provider selected on Patient Demographic Screen, but can be changed.

> ***Note:*** *This Providers name and PIN#'s will be used for billing purposes, unless you check the box* ***Use Provider listed in Patient File*** *in* ***Misc. Defaults*** *in* ***Properties.*** *Then the provider set as a default in the patient file will always be used for billing, regardless of who is selected here during the charge entry process. Also, please note the provider used for billing is the provider the charges will show up for in reporting.*

Units - Select the appropriate units of service and Quick-MD will automatically multiply units x times cost, if turned on in **Properties/ Misc Defaults/Multiply Units when entering Charges**.

***Note:** This feature will work ONLY if it is turned on in **Miscellaneous Defaults** (for more information see page 91) and the price is set in CPT Records.*

Minutes – Use this feature to have Quick-MD calculate the units for you using the ratio x:15, where x is the number of minutes entered into this field.

Place of Service – Use this feature to enter the place of service. *(for more information see page 82)* Will default to what is set in CPT Records.

Type of Service - Use this feature to enter the Type of service. *(for more information see page 83)* Will default to what is set in CPT Records.

Location - This feature is used for reporting only! Quick-MD has the ability to track up to 10 separate office locations. Will default to what is set in CPT Records.

EPSDT – Applies to the EPSDT field on the HCFA form.

EMG – Applies to the EMG field on the HCFA form.

COB – Applies to the Coordination of Benefits field on the HCFA form.

Medicaid Prior Auth. # - If your Medicaid intermediary wants the prior authorization number to be placed in block 24k on the 1500 form, enter number here. If they want it in block 23, then set it in the Supplier form in **Pre authorization #** field.

Comment – Use this feature to enter a comment that will appear in the patients ledger in the Com/Check Field. If you have the feature in **Properties/Misc. Defaults/ "Always put Service Date on ledger screen"** turned on, then it puts the from date of service in the comment field if it is different than the ledger date.

***Note:** To force Quick-MD to use a historical Primary Insurance company when generating a claim, insert @ followed by the insurance **Id#** in the comment field for the historical insurance company you wish to use.*

*The available historical insurance companies for that patient, if any, will be listed to the right of the comment field. (See picture above) This feature will overrule the auto decide insurance function which is found in **Properties/Miscellaneous Defaults** (for more information see page 91).*

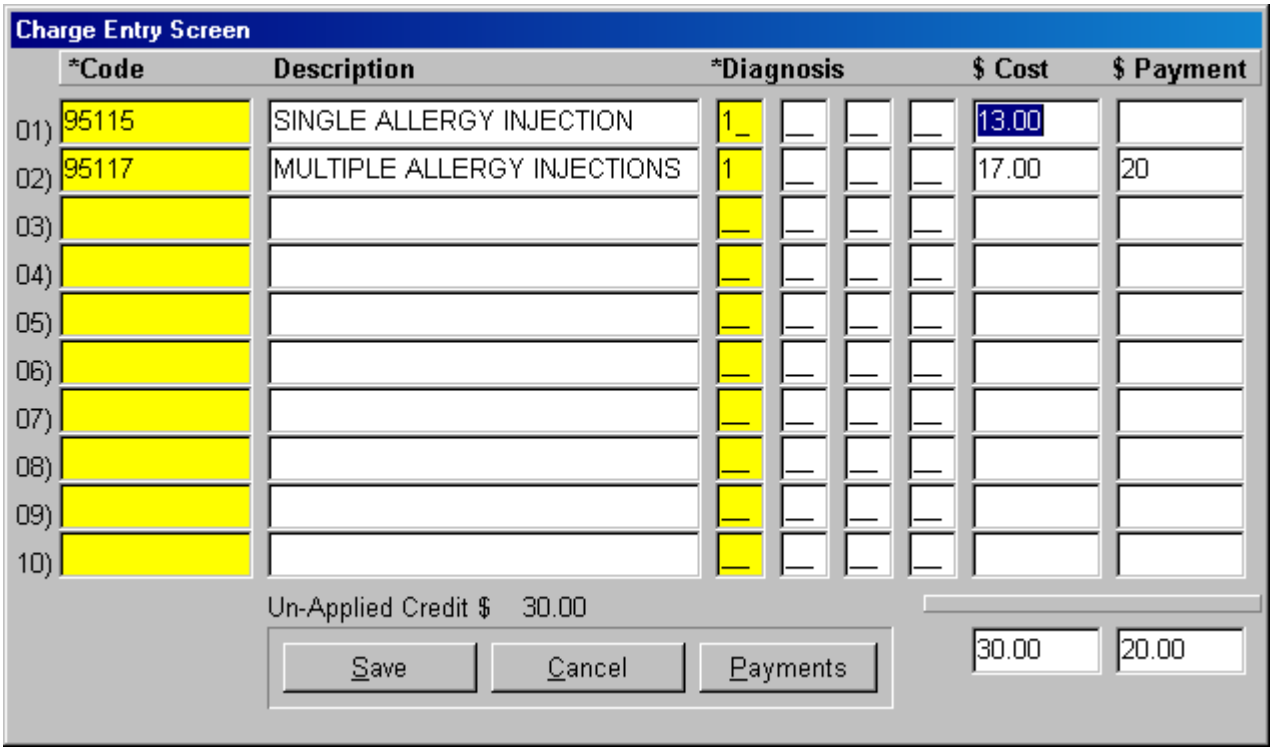
Modifiers – You can either type in the modifier to be used or hit **<F1>** to browse the table. A Cpt code may have the modifier pre attached with its own house code. This would preclude you from entering the modifier separately.

Click ***<Ok>*** to save and exit the ***Other Charge Information Screen.***

Step Four: Enter All Other Information Relating to the Charge

$Cost - when procedure code is selected, system will automatically bring over the charge that has been set in CPT records, or if there is a fee schedule attached to this patients insurance company, it will use their fee schedule, or the charges may be manually added.

$Payment - This feature allows you to post payments to each procedure. After payment amount is entered, "Payment Information" box will appear which allows you to input check number and payment type being made. If the feature in **Properties/Misc. Defaults/Ask if you want to print a receipt** is turned on, the system will ask you if you want to print a receipt when this claim is finished. *(for more information see page 91)* If no payment is being made leave payment field blank.

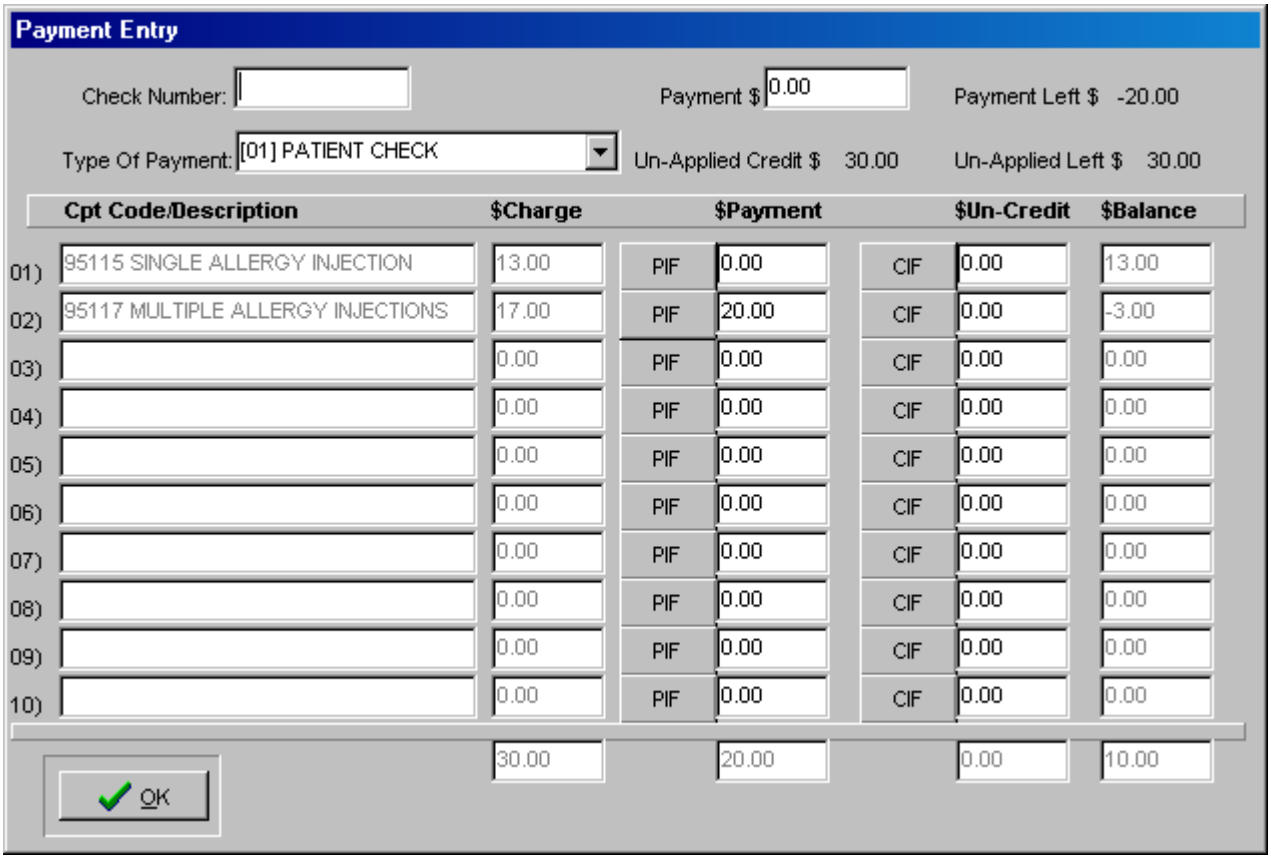


STEP FOUR: Applying Un-Applied Credits to this charge

The Payments Screen - using Un-Applied Credits
At the bottom of the charge entry screen this patients unapplied credit balance will be displayed. If you wish to apply them to this charge then click on the ***PAYMENT*** button at the bottom of the screen.

Enter the check number, the total amount being paid in the payment field, & select the type of payment. The charges are automatically brought over from the charge entry screen. Enter the amount applied to this charge. The "PIF" button will pay in full if so desired.
You may also use any unapplied credits at this point, either by typing in the desired amount or clicking "CIF"(credit in full). The system will display amount of payment left, un-applied credits used, unapplied credits left, total of charges, total payments made, and balance of the claim.

> ***NOTE***: *If you need to put money into this patient's un-Applied credits, when you finish this charge, pull in your CPT record "Credit" in the next available yellow *Code field (must be a CPT record in the main tables that has credit in the house code and credit in the CPT number, with a description of your choice, i.e. patient deposit, that is a 0.00 (zero) dollar charge) and enter the amount of the deposit in the payment field. This will add this amount to his unapplied credits.*

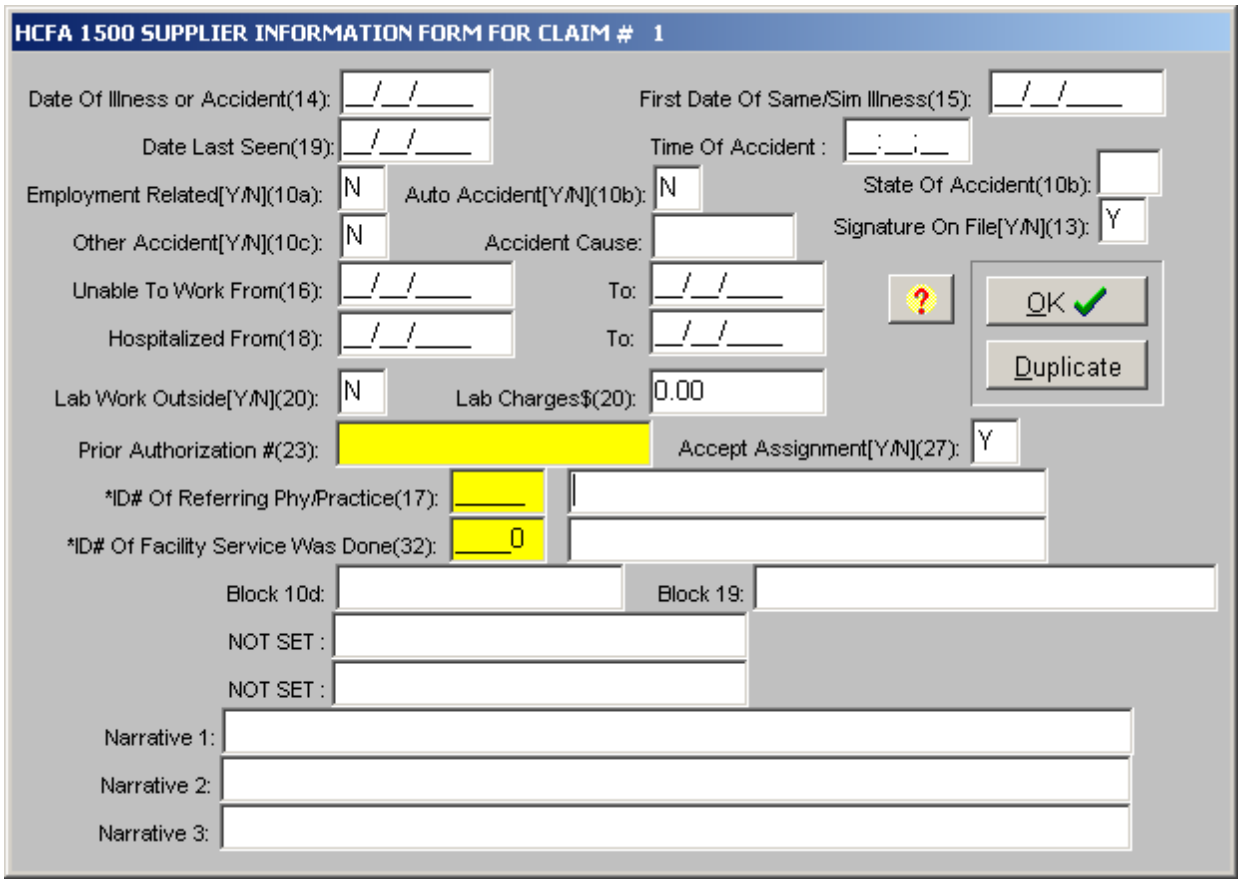

Payment Entry
Check Number:
Payment $ 0.00
Payment Left $ -20.00
Type Of Payment: [01] PATIENT CHECK
Un-Applied Credit $ 30.00
Un-Applied Left $ 30.00
Cpt Code/Description
$Charge
$Payment
$Un-Credit
$Balance
01) 95115 SINGLE ALLERGY INJECTION 13.00 PIF 0.00 CIF 0.00 13.00
02) 95117 MULTIPLE ALLERGY INJECTIONS 17.00 PIF 20.00 CIF 0.00 -3.00
03) 0.00 PIF 0.00 CIF 0.00 0.00
04) 0.00 PIF 0.00 CIF 0.00 0.00
05) 0.00 PIF 0.00 CIF 0.00 0.00
06) 0.00 PIF 0.00 CIF 0.00 0.00
07) 0.00 PIF 0.00 CIF 0.00 0.00
08) 0.00 PIF 0.00 CIF 0.00 0.00
09) 0.00 PIF 0.00 CIF 0.00 0.00
10) 0.00 PIF 0.00 CIF 0.00 0.00
30.00 20.00 0.00 10.00
OK

When finished in the payment screen, hit OK to save.

Once all charges are entered on the claim you, select the **Save** button. This will bring up the **Supplier Information Form, if this is an insurance responsible claim**.(if you wish for this screen to be displayed on (P) patient responsible claims also, check the box in **Properties/Misc. Defaults/ Always pop supplier form**) (for more information see page 91).

Step Five: Enter Supplier Information Needed to Complete the HCFA

Supplier Other Information Form
The supplier form is the balance of the information that applies to this claim as a whole.



Note: *The number in parenthesis behind the field descriptions corresponds to the block number of these fields on the HCFA 1500 form.*

From the yellow **Prior Authorization** field, hit the **<F1>** key to access the **Managed Care Module**. You may then double click on the authorization number that applies to this charge, and Quick-MD will automatically populate both the authorization number (block 23 on the 1500 form) field and the referring physician if set. The ID# of the Referring Physician (block 17 and 17a on the 1500 form) and ID# of Facility where services are rendered (Block 32 on the 1500 form) are entered here. The **<F1>** key allows the user to browse the table and make the appropriate selection. The **<F10>** key allows the user to add records on the fly. Should this information be the same as the last claim, hit the duplicate key. Quick-MD is designed to allow the user the flexibility of the cursor starting in either the "Date of Illness" field if you do a lot of workers comp or in the ID# of Referring Physician, for those offices who don't deal with workers comp very often. This cursor default is in **Properties/Misc. Defaults/"Go Directly to Referring Physician on Supply open"**

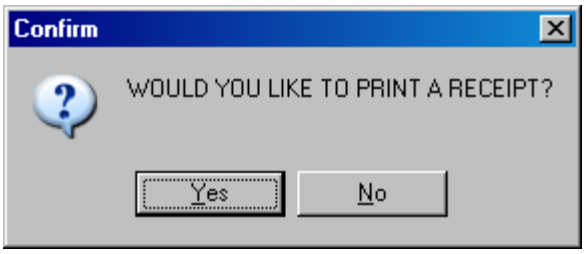
Note: Miscellaneous Defaults *allows the user to turn on/off "Go Directly to Referring Phy. On Supplier Form Open" (for more information see page 91). If this option is turned on, the prompt will start at the Referring Physician field and will skip over all of the information above it. This, however, does not preclude you from entering data in the fields you skipped over. It is merely done for convenience and ease of use.*

Note: *The two blank boxes below blocks 10d and 19 are extra, undefined fields that you can define for use in* ***Set 1500 Extra Data Fields*** *(for more information see page 84).*

The last three lines give the user the ability to send up to three lines of text when the claim is filed electronically. These 3 fields are commonly referred to by the payers as the HAO record or the Narrative Record.

The **Duplicate** button allows the user to copy the information in this screen from the previous claim for this patient.

Select the **<OK>** button to save



The **CONFIRM** window allows you to print a receipt.

NOTE: *This feature can be turned on or off in* ***MISCELLANEOUS DEFAULTS*** *IF YOU DO NOT PRINT RECIEPTS AT THE WINDOW (for more information see page 91)*

ENTER CHARGES PATIENT CLAIM

This feature allows you to enter charges for a Self Pay claim assigning the **(P)** patient responsibility to the claim, even if the patient has insurance. It works the same as above.
See Steps 2 through 7 above for completing Patient Claim Charges.

ADD CHARGES TO LAST CLAIM

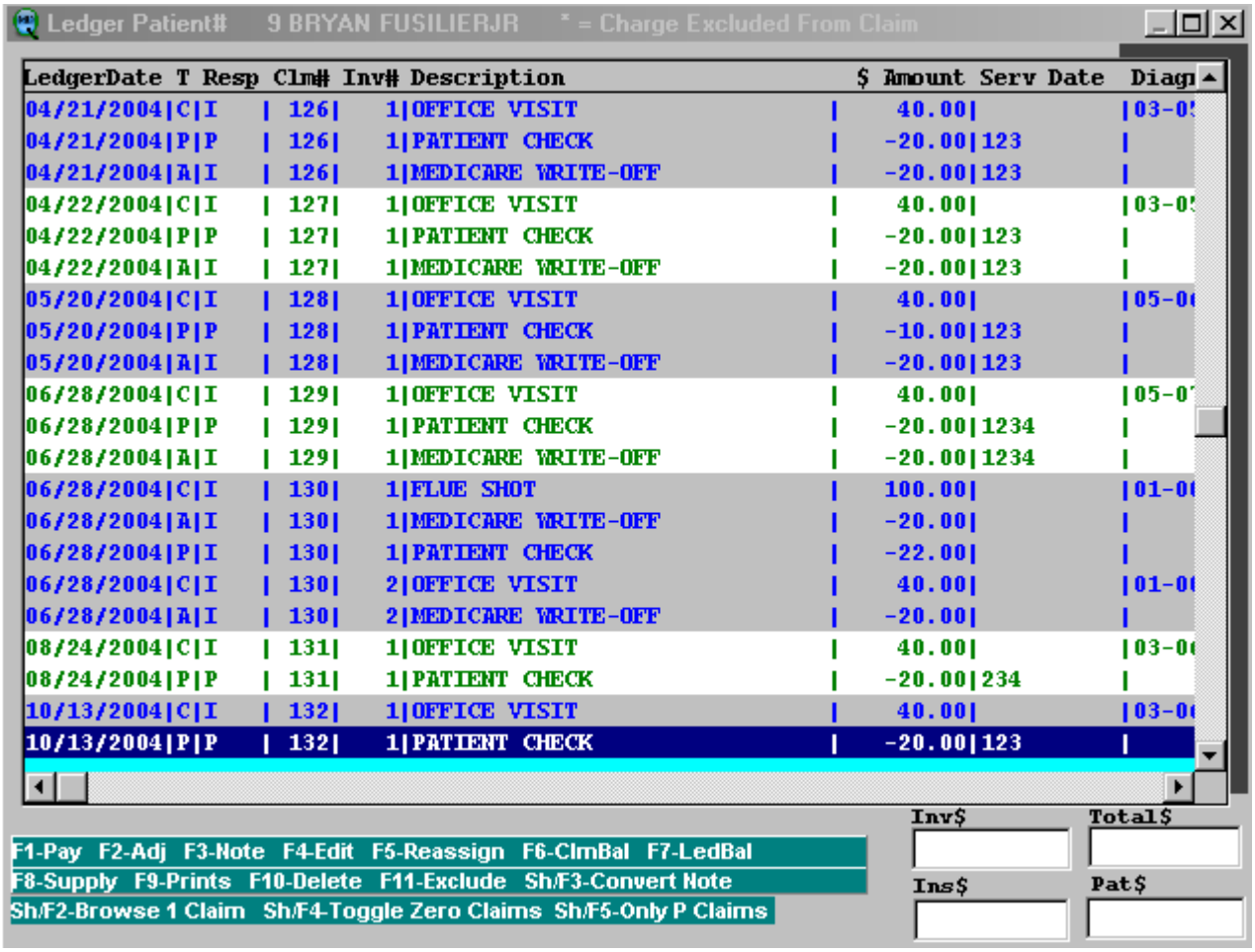
This feature allows you to attach additional charges to the last claim saved in the Patient's Ledger, if they have not been billed. If they have been billed, Quick-MD will automatically start a new claim.

NOTE: *You can have Quick-MD check to see if the last claim in the Ledger has the P responsibility and to create a new claim instead of adding charges to a claim that is now the responsibility of the Patient. This is set in the CPT Entry options found under the Properties menu. (for more information see page 80)*

See Steps 2 through 9 above to complete Adding Charges To Last Claim. If last claim saved was a Patient Claim Charge, see Steps 2 through 7 only

Current Ledger

The current Ledger is where you go to view all details about your patient's claims. The Ledger is fully functional in the sense that you can post payments, adjust charges, edit entries, post notes and reassign responsibilities all from within this one screen.


Ledger Patient# 9 BRYAN FUSILIERJR * = Charge Excluded From Claim
LedgerDate T Resp Clm# Inv# Description $ Amount Serv Date Diagn
04/21/2004|C|I | 126| 1|OFFICE VISIT | 40.00| |03-0
04/21/2004|P|P | 126| 1|PATIENT CHECK | -20.00|123 |
04/21/2004|A|I | 126| 1|MEDICARE WRITE-OFF | -20.00|123 |
04/22/2004|C|I | 127| 1|OFFICE VISIT | 40.00| |03-0
04/22/2004|P|P | 127| 1|PATIENT CHECK | -20.00|123 |
04/22/2004|A|I | 127| 1|MEDICARE WRITE-OFF | -20.00|123 |
05/20/2004|C|I | 128| 1|OFFICE VISIT | 40.00| |05-0
05/20/2004|P|P | 128| 1|PATIENT CHECK | -10.00|123 |
05/20/2004|A|I | 128| 1|MEDICARE WRITE-OFF | -20.00|123 |
06/28/2004|C|I | 129| 1|OFFICE VISIT | 40.00| |05-0
06/28/2004|P|P | 129| 1|PATIENT CHECK | -20.00|1234 |
06/28/2004|A|I | 129| 1|MEDICARE WRITE-OFF | -20.00|1234 |
06/28/2004|C|I | 130| 1|FLUE SHOT | 100.00| |01-0
06/28/2004|A|I | 130| 1|MEDICARE WRITE-OFF | -20.00| |
06/28/2004|P|I | 130| 1|PATIENT CHECK | -22.00| |
06/28/2004|C|I | 130| 2|OFFICE VISIT | 40.00| |01-0
06/28/2004|A|I | 130| 2|MEDICARE WRITE-OFF | -20.00| |
08/24/2004|C|I | 131| 1|OFFICE VISIT | 40.00| |03-0
08/24/2004|P|P | 131| 1|PATIENT CHECK | -20.00|234 |
10/13/2004|C|I | 132| 1|OFFICE VISIT | 40.00| |03-0
10/13/2004|P|P | 132| 1|PATIENT CHECK | -20.00|123 |
F1-Pay F2-Adj F3-Note F4-Edit F5-Reassign F6-ClmBal F7-LedBal
F8-Supply F9-Prints F10-Delete F11-Exclude Sh/F3-Convert Note
Sh/F2-Browse 1 Claim Sh/F4-Toggle Zero Claims Sh/F5-Only P Claims
Inv$
Total$
Ins$
Pat$

Alternating font colors and background shadings distinguish all Claims in the Ledger from one another. Each Ledger Entry contains several columns, each of which are named by the column headings.

Ledger Date – Date Entry was made in the Ledger.

T – Type of Entry. Quick-MD will put a (**C**) for a charge, (**A**) for an adjustment, (**P**) for a payment or an (**N**) for a note.

Resp – Shows the user the responsibility of this Entry: (**I**) for Primary Insurance, (**S**) for Secondary Insurance, (**A**) for Third Insurance and (**P**) for Patient Responsibility.

> ***Note:*** *These codes are how Quick-MD knows who to bill a claim to. When a claim is billed, Quick-MD will put a red billing note directly under the claim that was billed. It will show the user the claim number billed and assign a responsibility number as follows: (1000) for Primary Insurance, (1001) for Secondary Insurance, (1002) for Third Insurance and (1003) for Patient Responsibility.*
>
> ***Note:*** *When the user tells Quick-MD to bill, whether on paper or electronically, Quick-MD runs through each ledger and looks at each claim that fits the responsibility code selected to bill: (**I**) Primary, (**S**) Secondary, (**A**) Third Insurance or (**P**) Patient Responsibility that does not have a **red billing note** (except patient statements-all patients with a balance will be re-billed regardless of a billing note). So it's very Important to understand these concepts of Responsibility Codes and Billing Notes. Quick-MD also shows the user the invoice number(s) that make up the claim under the INV heading.*

Clm# - Claim Number

Inv# - Invoice Number

Description – Description of Ledger Entry

Amount – Amount of Entry, if applicable.

Com/Chk# - will put the comment from the charge entry here or the check number from payment posting. Unless the feature in **Properties/Misc. Defaults/"Put service date on ledger screen"** is turned on. Then the "from date of service" will appear in this field if it is different form the ledger date.

Diagnosis – list the pointers to the patient's diagnosis table

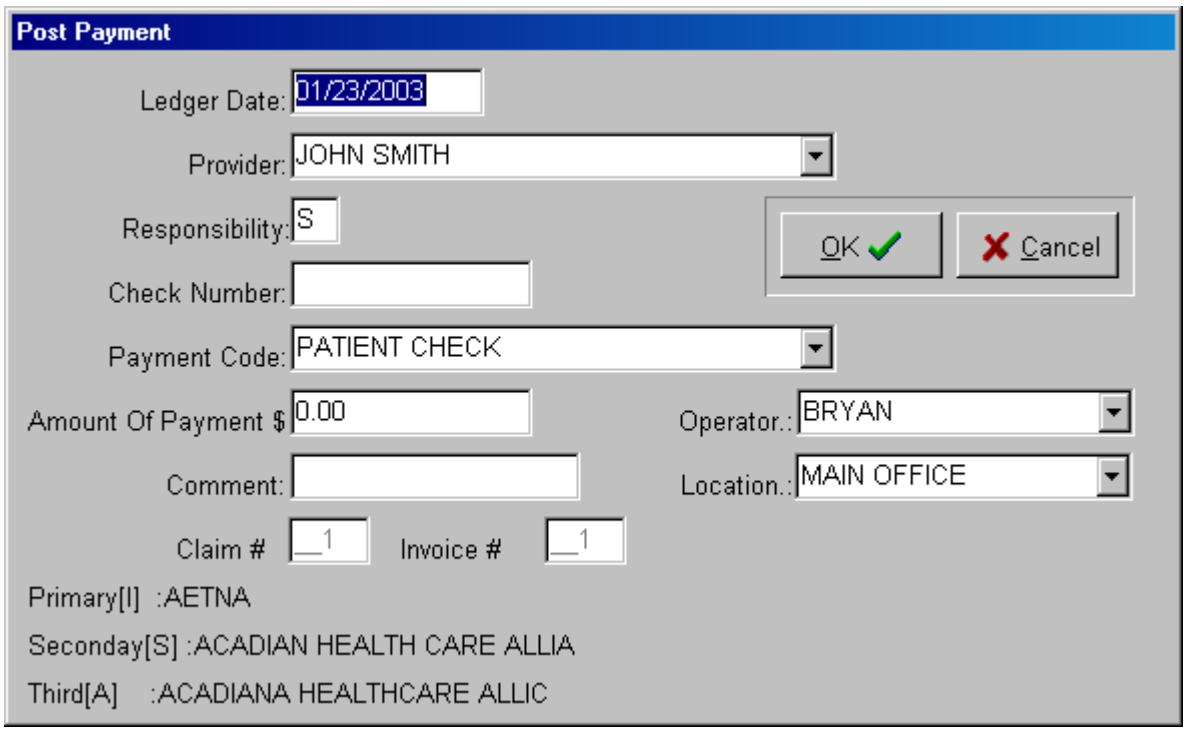
> ***Note:*** *Checking "Put Primary Diagnosis on Ledger Browse" under Properties/File Browser Setting, well set the first diagnosis in this column instead of the pointers.*

From Date – from date of service

To Date – to date of service

To make entries, changes or view additional information, **highlight** the invoice or claim in question using the Up and Down arrows keys to move the highlight bar, and use the **F keys (1 through 11)** as listed below: These commands are listed across the bottom of the screen for your convenience.

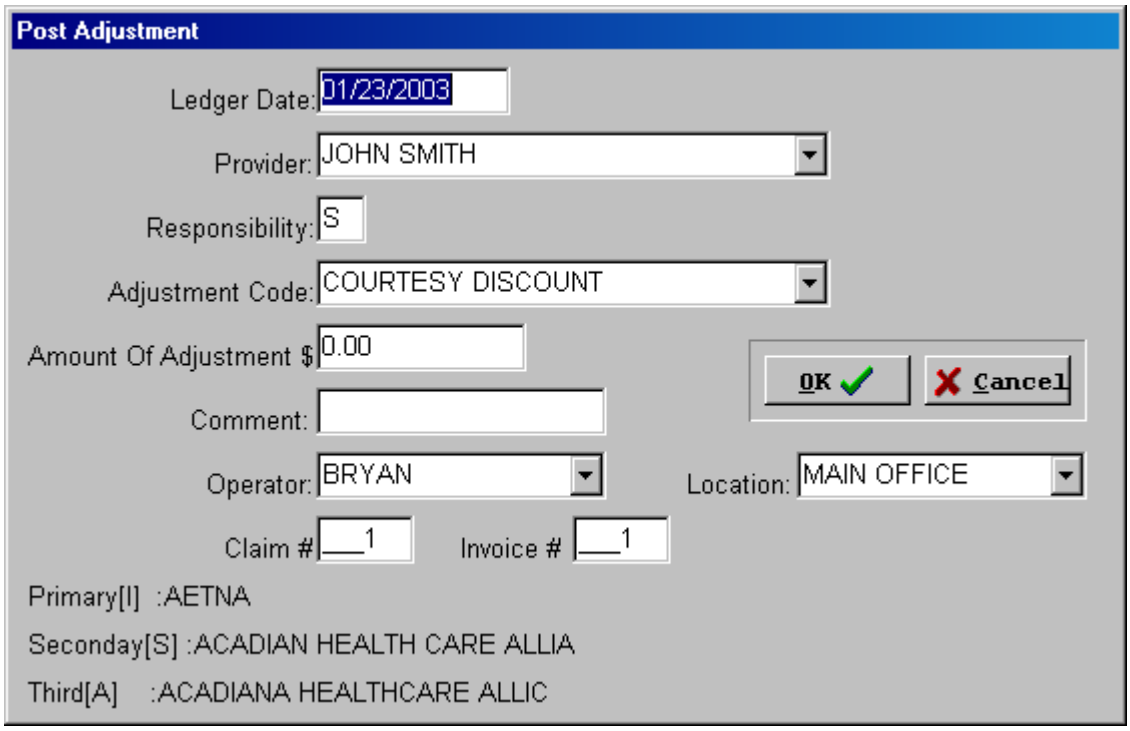
<F1> (Pay) - allows the user to post a payment to the highlighted claim as a whole or each line item.



> ***Note:*** *ALWAYS POST PAYMENTS TO THE INDIVIDUAL CLAIM BEING PAID. NEVER POST ALL PAYMENTS TO ONE CLAIM or just to the last claim the ledger.*

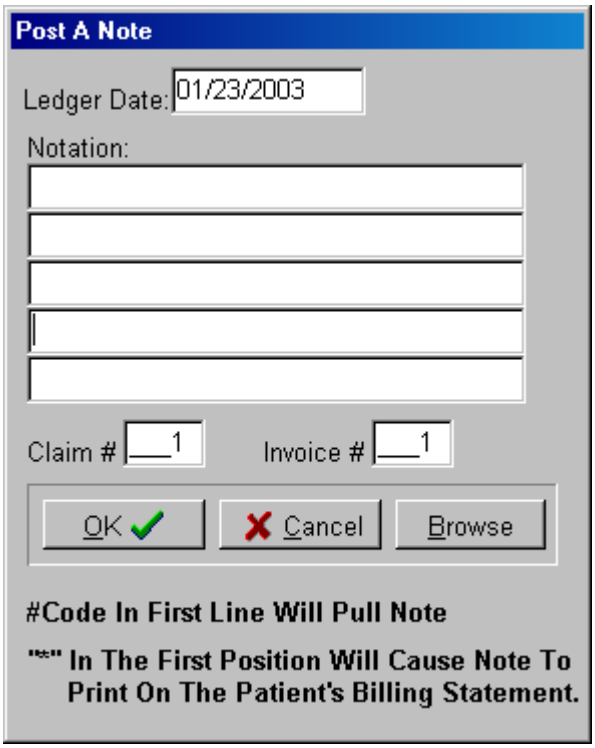
> ***Important!*** *Remember all claims must eventually come to a zero balance, either through payments or adjustments!*

<F2> (ADJ) - allows user to post an adjustment to the highlighted claim as a whole or each line item.



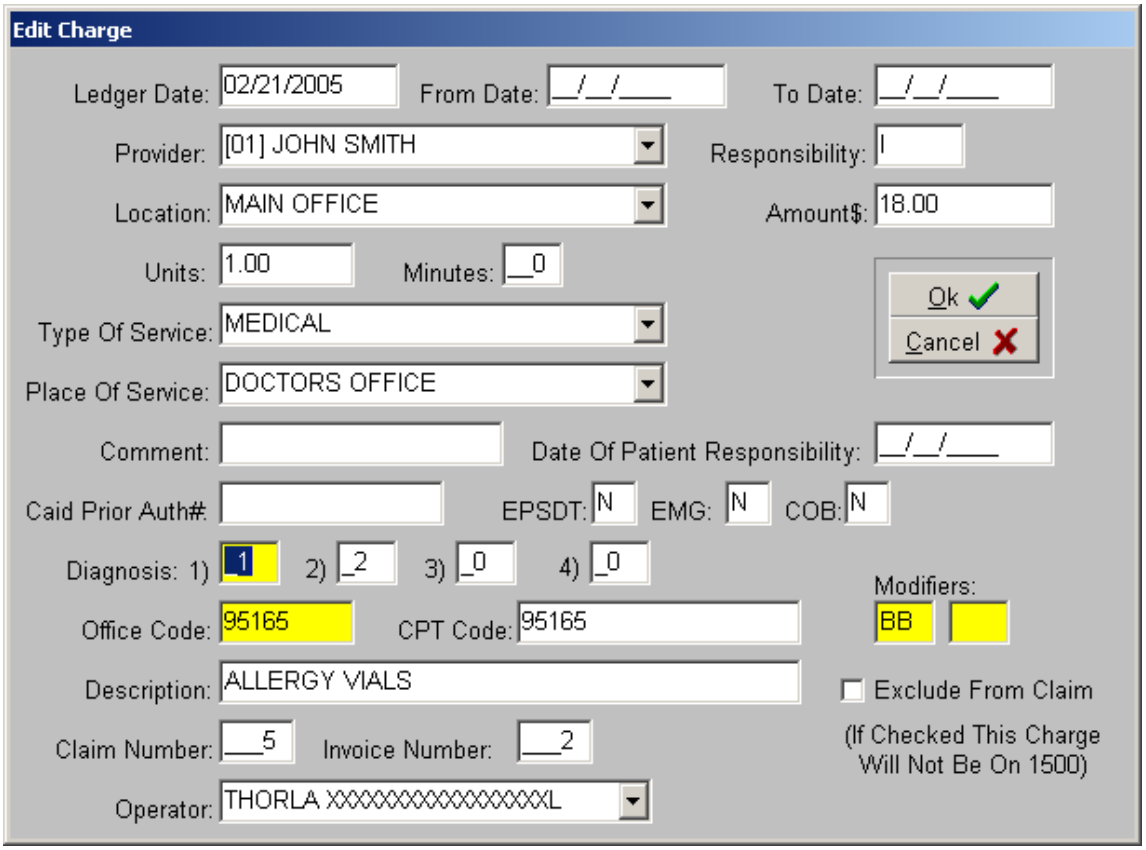
IMPORTANT: *Always post adjustment to the individual claim being adjusted. Never post all adjustments to one claim in the ledger or at the bottom of the ledger.*

<F3> (NOTE) - allows the user to post a note to the highlighted claim, up to five lines in length, and gives the user the option to have the note printed on the Patient's billing statement if you proceed the note with an (*)asterisk.



BROWSE – Use this feature to select from any of the **CANNED NOTES** you have set up. *(for more information on setting up CANNED NOTES see page 289).*

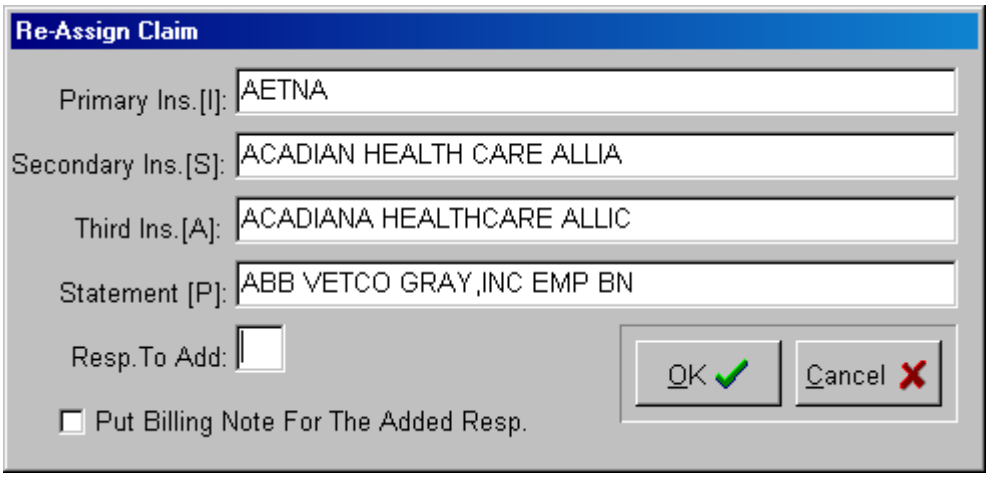
<F4> (EDIT) - Use this feature to edit any Entry in the ledger.



NOTE: *To force the system to utilize a historical Secondary Insurance company when generating a claim, insert "**&**" followed by the insurance **Id#** in the **comment** field for the historical insurance company you wish to use. Quick-MD will auto decide which one to use based on the date of service, if this feature is turned on in **Properties/Misc. Defaults/Auto decide Insurance to use** (for more information see page 91)*

NOTE: *If you change the CPT Code to a different code than the one listed and want Quick-MD to automatically update the price, you will need to set that option in Properties-Misc. Defualts. (For more information see page 91)*

<F5> (REASSIGN) - Use this feature to Re-assign the claim. (To re-assign the billing responsibility to another pay source)



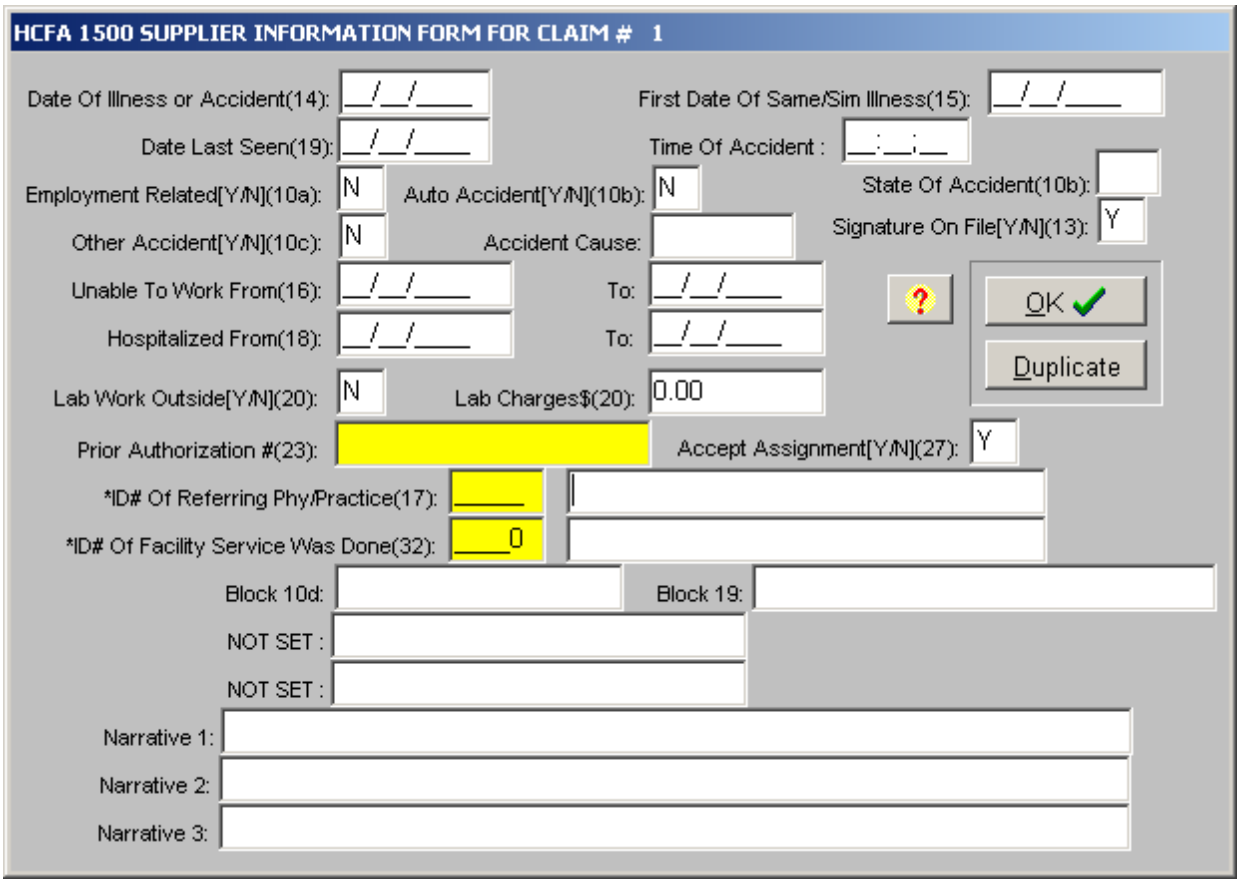
***NOTE**: To re-assign to a historical Secondary Insurance company, you must use the Edit charge feature **<F4>** or let the system auto decide which one to use. (for more information see **EDIT CHARGE** feature above)*

***NOTE**: If you know the company you are reassigning responsibility to is an automatic crossover (medigap company), check the box "put billing note for added responsibility" and the system will not pick this claim up and bill it. But it will then be reassigned and in the proper reporting.*

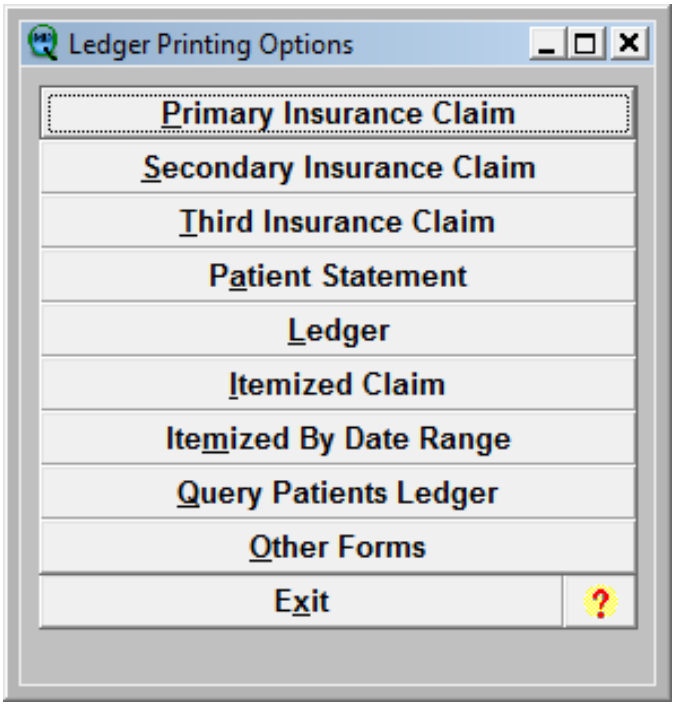
<F6> (CLM-BAL) - Use this feature to view the balance of each claim selected. Use the up and down arrow keys to highlight the claim, then press the **<F6>** key for the claim balance. The balance of the Invoice highlighted will also be displayed in the **INV**. box. The **Total** box will display the claim balance.

<F7> (LED. BAL) - Use this feature to display the entire ledger claim balance in detail

<F8> (SUPPLY) - Use this feature to edit and view the **HCFA 1500 SUPPLIER INFORMATION SCREEN**



<F9> (PRINT) - Use this feature to print various forms from the Ledger.



Primary Insurance Claim – Prints a Primary Insurance HCFA form from claim.

Secondary Insurance Claim – Prints a Secondary Insurance HCFA form from claim.

Third Insurance Claim – Prints a Third Insurance HCFA form from claim.

Patient Statement – Prints a Patient Statement from the claim.

Ledger – Sends the Patient's Ledger to the **Data Output Processor**.

Itemized Claim – Sends an Itemized Claim to the **Data Output Processor**.

> ***Note:*** *This is the same report used when printing a patient's receipt. If a patient requests another receipt, you would go to the claim and print this option.*

Itemized by Date Range – Sends Itemized Claims defined by a date range to the **Data Output Processor**.

Query Patients Ledger – Allows you to run a number of different queries on the patient's ledger.

- Report All Payments Only
- Report Patient Payments Only
- Report Insurance Payments Only
- Report Charges and Payments
- Report Charges, Payments and Adjustments
- Report Charges Only
- Report Notes Only
- Report Only Claims With a Balance

Other Forms – This item will only be available in Texas

- Print the Texas Workers Compensation form DWC-73
- Print the Texas Workers Compensation form DWC-69

Exit – Exits the print menu.

<F10> (Delete) – Use this feature to delete the highlighted entry.

Note:** Can only be used if user has been given the right to do so. (for more information see page 286) Also, any ledger deletion, with the exception of billing notes, can be reported on in **System Utilities/Run Deleted Ledger Record Reports

<F11> (Exclude) – Use this feature to exclude the highlighted charges from printing on the claim. Charges that have been excluded will have an asterisk next to them in the ledger. This is the way to exclude invoice(s) paid, fix invoice(s) denied by editing and re-billing the claim, (simply by hitting the F9 print key) only with the one that needs rebilling.

***Note:** Be sure to hit the F11 after reprinting the form to remove the asterisk(s) so that those invoices will be picked up when this claim is reassigned to secondary insurance.*

<Shift> + <F3> (convert billing note) – Use this feature to change a red billing note into a regular note. The note number will become 999. This type of note will let the system re-bill a claim, but stays in the ledger for audit trail purposes.

***Example:** In the past, in order to re-file a claim you needed to delete the billing note for Quick-MD to pick up the claim in the next filing run. Now, you can simply change the billing note to a regular note, which gives you a more accurate audit trail.*

<Shift> + <F2> (Browse 1 Claim) – Allows you to filter the patient ledger so that it displays only the claim you are interested in working with.

<Shift> + <F4> (Toggle zero balance claims) – Allows you to filter the patient ledger so that it displays only the claims that have a balance. This will hide all zero balance claims from being displayed, which can make the ledger easier to read in certain high volume practices.

***Note:** You can set all ledgers to default to hiding zero balance claims with a check box in the Browser Default window. (For more information see page 76)*

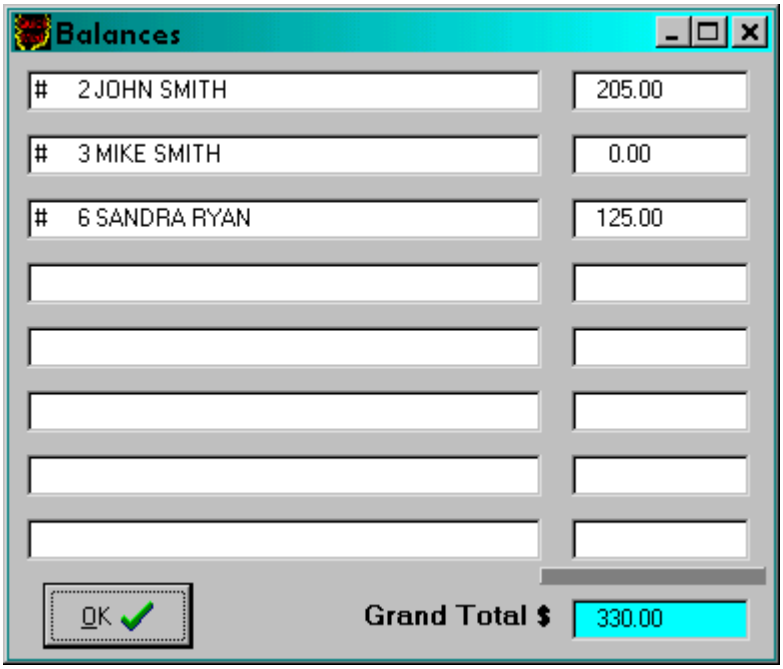
History Ledger



This feature stores all zero balance claims that were moved from the current ledger to history via the **Move Ledges To History feature** found in **System Utilities** *(for more information see page 286)*

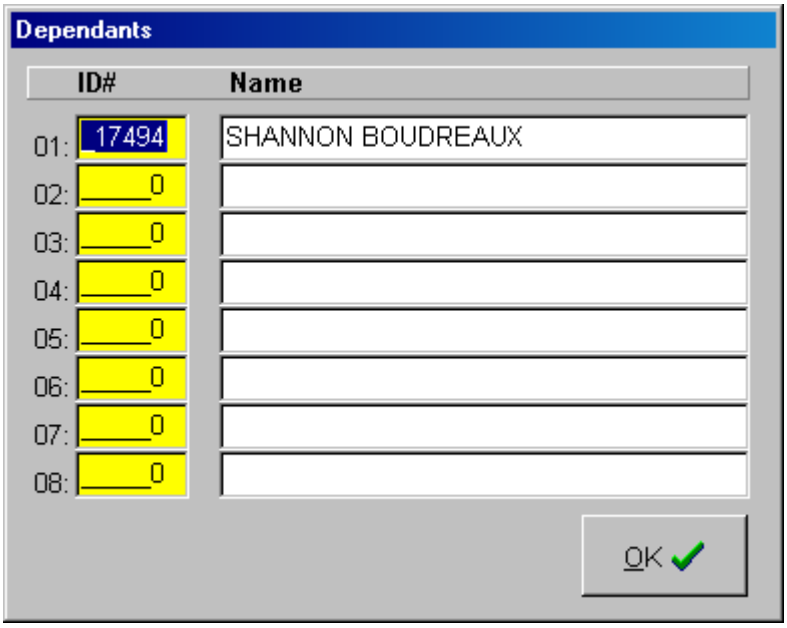
IMPORTANT: *Once zero balance claims are moved to History Ledger, no reports can be generated on those claims and there is no way to move them back to Current! So be sure this is the desired result!*

Dependant Balances



This feature will display all dependant balances that are listed in the Dependant Ledger, with the total for the family listed in the grand total. This information is available from any of the patients that are tied together. *(for more information see **Dependents** below)*

Dependants



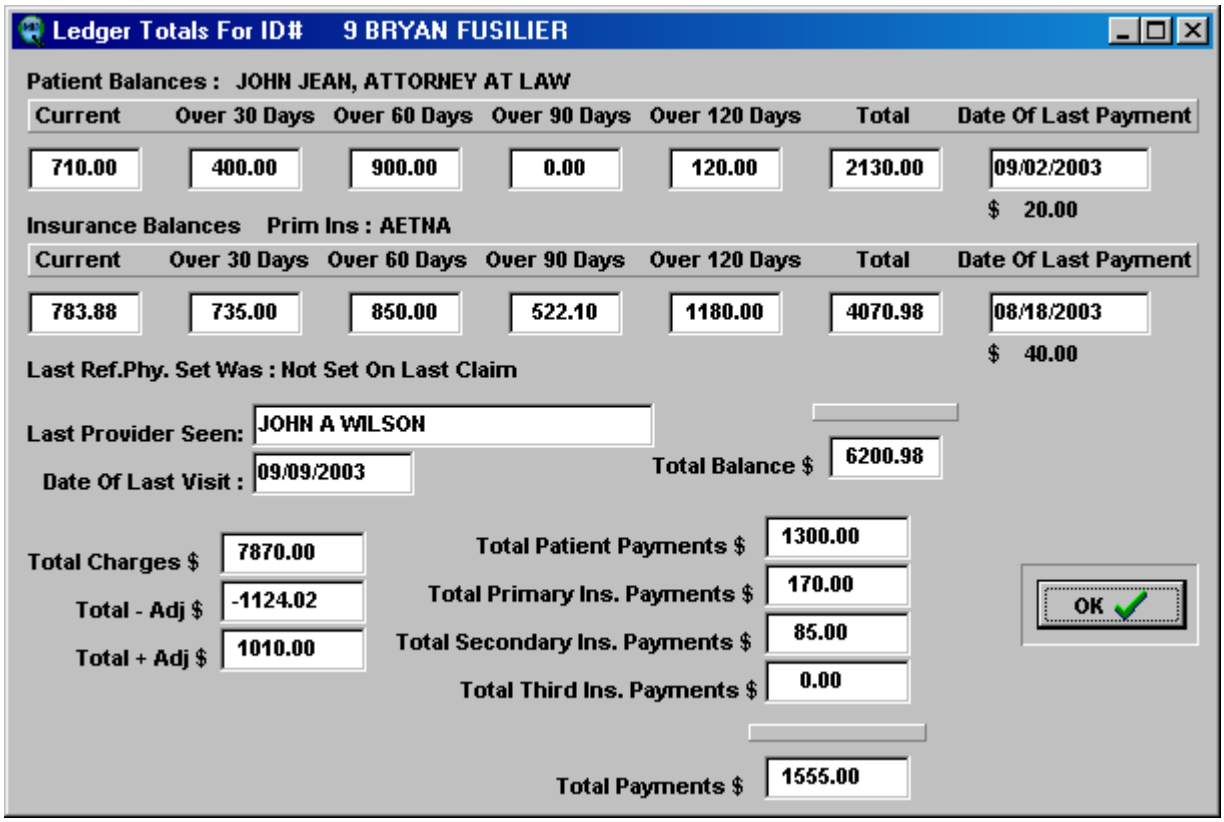
This feature allows for tying all the Dependants ID# numbers and their names to the account of the Guarantor or to attach family members accounts. From the guarantors account, simply hit the **<F1>** key in the yellow field, browse the patient file, and bring in the one you want to select. Once this is done, the dependant's balances button can be accessed from any dependant's account or the guarantor's account.

Exit

This feature exits the Patient Ledger.

[BALANCES] - PATIENT LEDGER BALANCES

This feature gives you the Ledger Totals for the Patient which includes the patient balances and insurance balances - Aged. Additionally you can see the Last Provider Seen, Date of Last Visit and Last Referring Physician Seen.

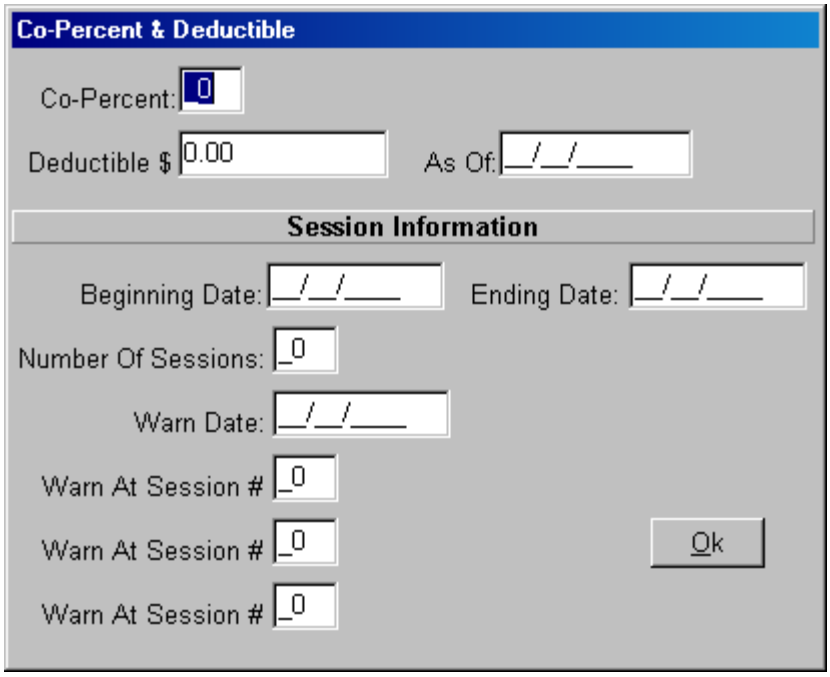


[INFO] - CUSTOM INFORMATION SCREEN

Use this feature to track any custom information you might wish to collect from your patients. There is a **MALE CUSTOM INFORMATION SCREEN** and a **FEMALE CUSTOM INFORMATION SCREEN**, each of which can be configured differently to handle different information. *(to configure see pages 73 and 73) This information may be printed out and attached to the chart for the Doctors review.*

[CO%] - CO-PERCENT & DEDUCTIBLE

This feature of the medical system allows you to bill the patient at the same time as the insurance company for the percentage or a set dollar amount of the bill that the insurance company is not going to pay.



To implement this feature based on a percentage:

Set the patients co-percent amount in the patient's financial information record. For example, if the patient's co-percent amount is 20%, then enter the number 20 in this data field. This MUST be done first.

When entering an insurance claim that you wish to bill the patient for the co-percent, place the “I” and “P” responsibilities on all of the charges for the claim.

Post a co-percentage billing note to the claim. This is done the same way as posting a regular note, but this note's description must start with a percent sign. You may enter anything you wish after the percent sign. The location of the note within the claim does not matter.

EXAMPLE - % CO-PERCENTAGE Patient BILLING

As long as this note is attached to the claim the patient will be billed for his set co-percent of this claim until that balance is paid.

If after you have received payment from the insurance company and it turns out that the patient is going to be responsible for more than the set co-percent amount the steps to take are:

Post the insurance payment to the claim.
Delete the co-percent note.

Quick-MD will now ignore the co-percent and bill the patient for the entire balance of the claim.

To Implement this feature based on a fixed dollar amount:

Post a co-percent billing note on the claim. This note needs to begin with a percent sign (%) followed by a dollar sign ($) and then the dollar figure including two decimal places (Example - %$50.00)

When entering a insurance claim that you wish to bill the patient for the fixed dollar amount, place the “I” and “P” responsibilities on all of the charges for the claim.

As long as this note is attached to the claim the patient will be billed for his fixed dollar amount of this claim until that balance is paid. If after you have received payment from the insurance company and it turns out that the patient is going to be responsible for more than the set fixed dollar amount the steps to take are:

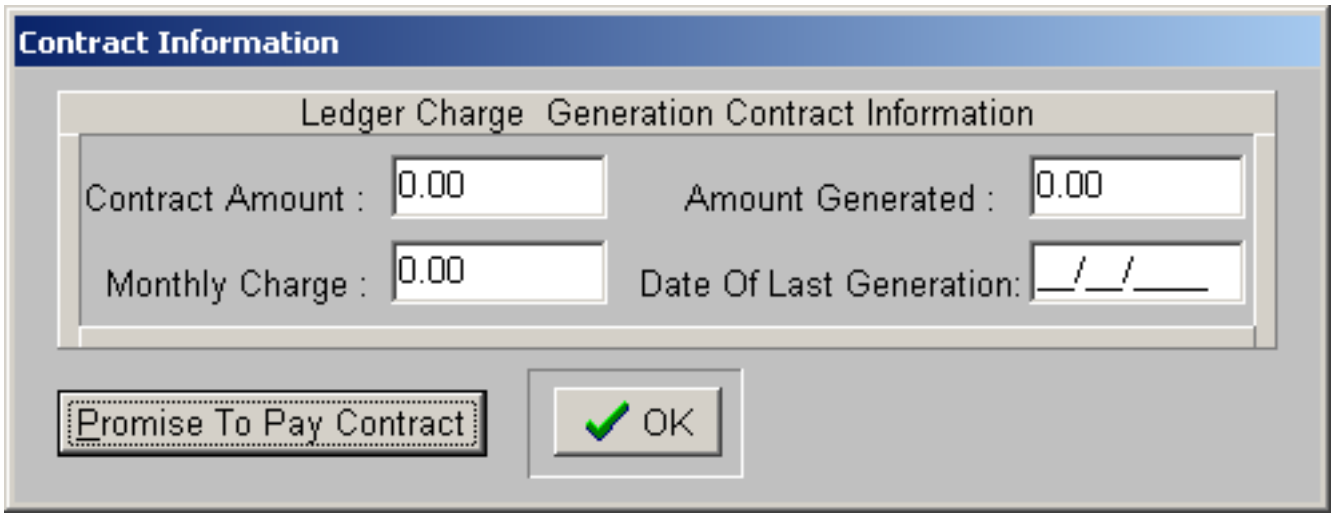
Post the insurance payment to the claim.
Delete the co-percent note.

Quick-MD will now ignore the co-percent and bill the patient for the entire balance of the claim

Session Information:
This feature will let you keep track of the number of sessions or a session date range that is valid for this patient. If you are using a date range you can have the system warn that the date range is about to expire by setting a date in the warn date field. If you have a fixed number of session available you can have the system tell you when you are almost out of session by setting a number in the warn at session fields. These warning will be displayed when you are entering charges.

[CONTRACT] - Contract Payment Information
This feature is utilized when patients are set up on a payment plan for a balance owed. The patient agrees to a certain monthly payment.

***Note:** The entire balance owed is adjusted off of the account utilizing a "write-off to contract adjustment code" **Adjustment Code Table** (for more information see page 68).*



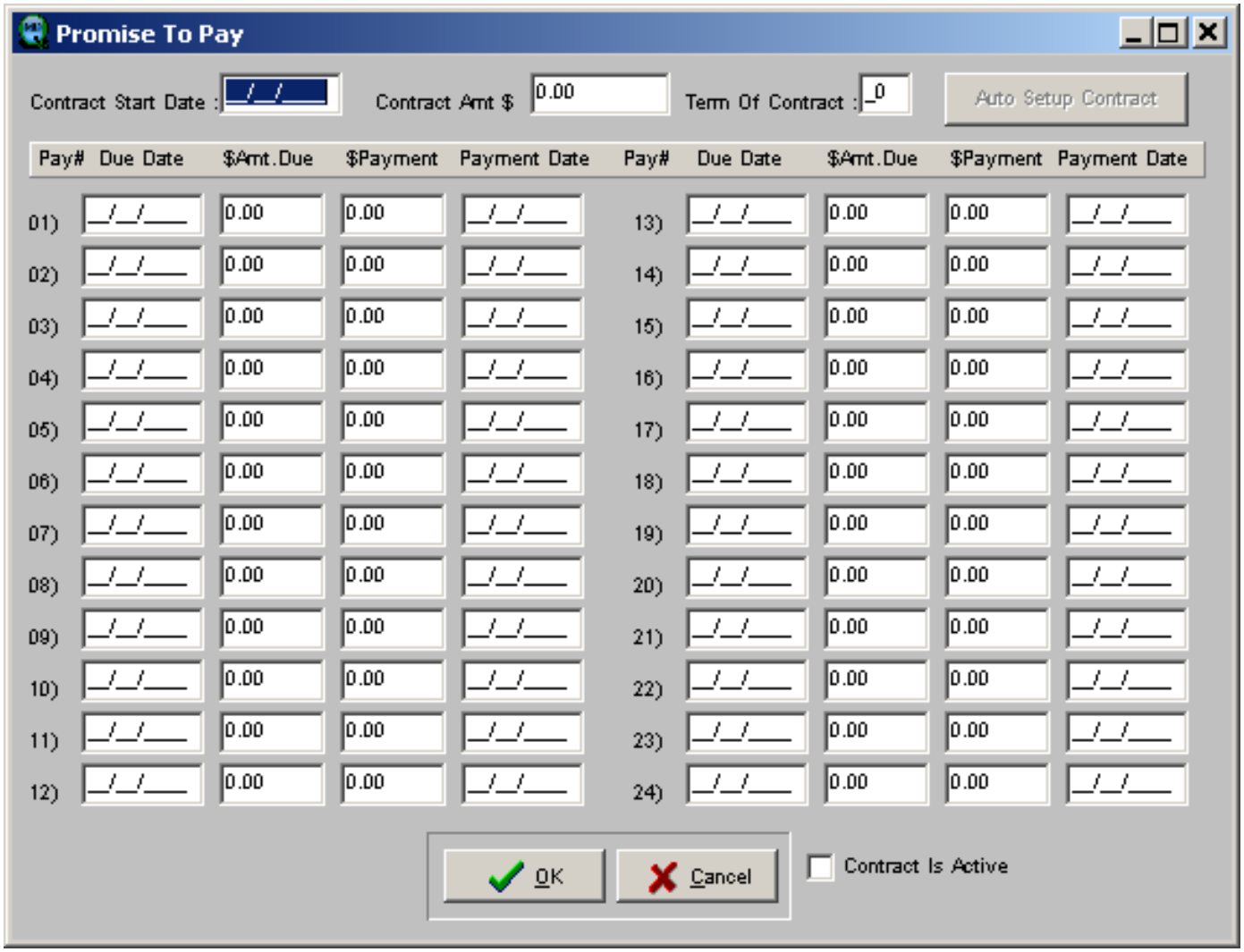
Contract Amount - the amount owed by the patient.

Monthly Charge - the amount the patient agreed to make on a monthly basis.

Amount Generated - Quick-MD will accumulate the amount billed at the end of each month.

Date of Last Generation - Quick-MD will download the last date and the total amount generated.

PROMISE TO PAY CONTRACT


Promise To Pay
Contract Start Date :
Contract Amt $
0.00
Term Of Contract :
0
Auto Setup Contract
Pay# Due Date $Amt.Due $Payment Payment Date Pay# Due Date $Amt.Due $Payment Payment Date
01) 02) 03) 04) 05) 06) 07) 08) 09) 10) 11) 12)
13) 14) 15) 16) 17) 18) 19) 20) 21) 22) 23) 24)
OK
Cancel
Contract Is Active

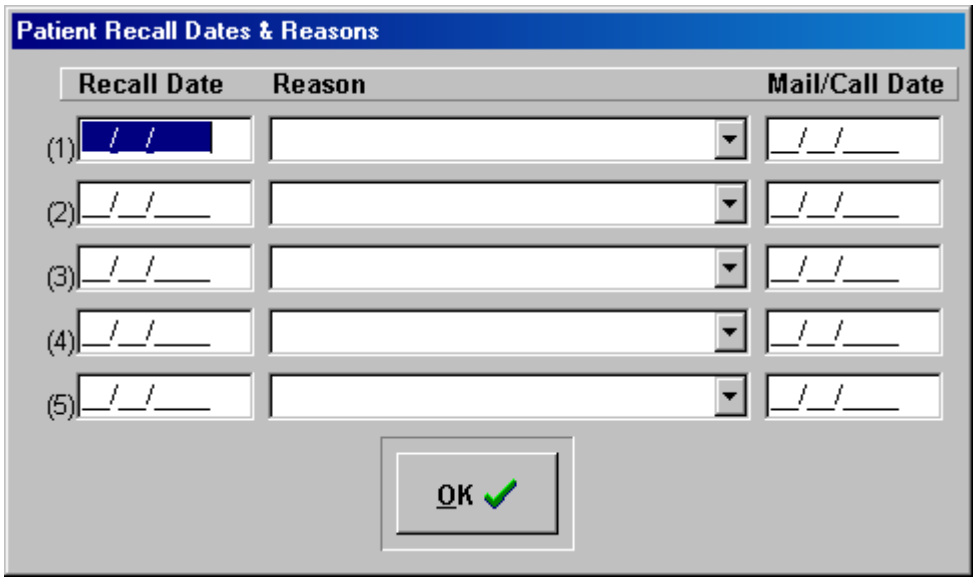
This form will allow you to setup, up to 24 expected payments. Once this form is set up, when the operator enters a payment with a **"P"** responsibility code, the system will ask the operator if it is a **PROMISE TO PAY** payment. If the answer is yes it will post the payment in the ledger and also into the promise to module.

Note: *There are two reports based on the information from the* ***PROMISE TO PAY*** *module. One will list past due payments and one will list all* ***PROMISE TO PAY*** *contracts and there statuses.*

Before running Patient statements, run **GENERATE CONTRACT LEDGER ENTRIES** (*for more information see page 292*) and this will go to all ledgers and apply the appropriate amounts to be billed.

[RECALLS] - PATIENT RECALLS

This feature allows the user to run a recall report. **(REPORTS/RECALL REPORT**). The Patient recall date & reason for recall will show up on the user defined recall report. Should you decide to send them a letter, Quick-MD will automatically track the date you merged with Word.



NOTE: *There is a* ***PATIENT RECALL REPORT*** *(for more information see page 279) that will tell the user who is being recalled and why. The table is user definable and located within* ***PROPERTIES*** *(for more information see page 75)*

Using Un-Applied Credits

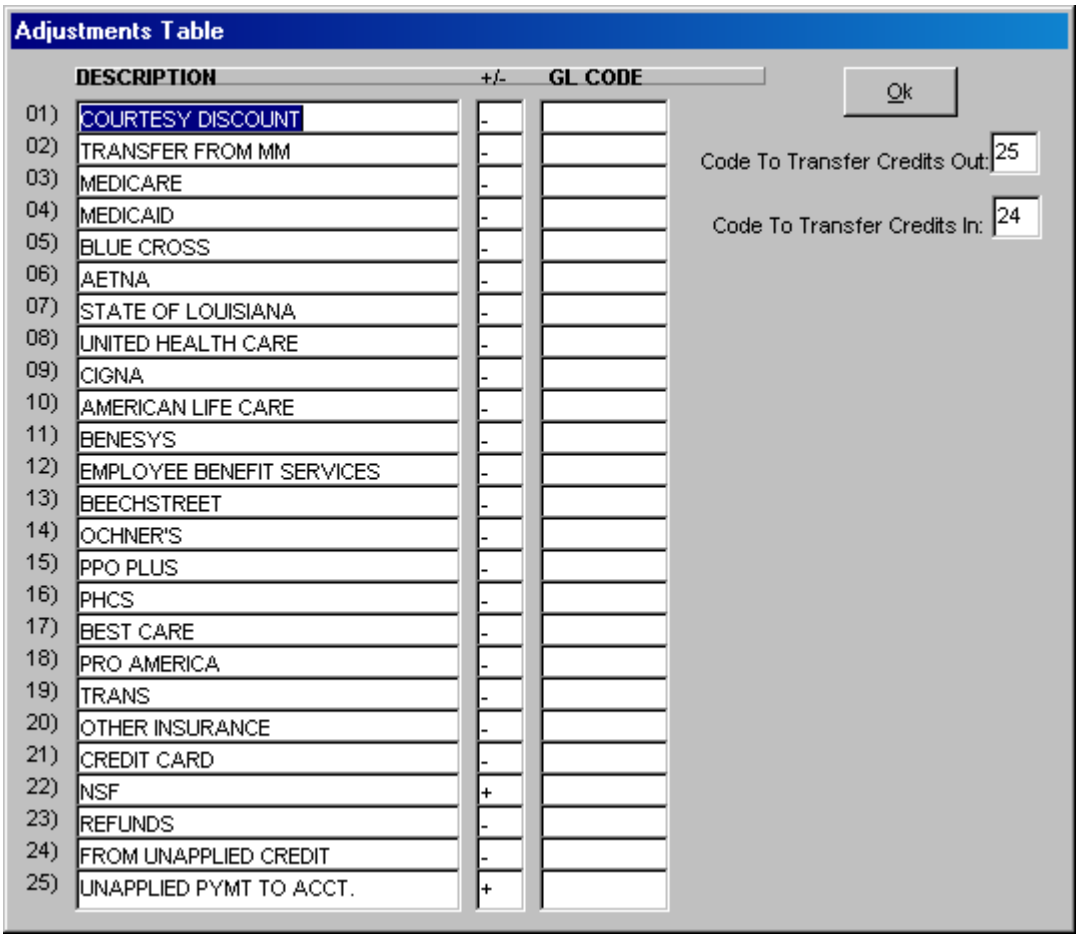
Quick-MD allows you to accept and track and apply un-applied credits from patient overpayments to accounts. Any time a patient over-pays you it will create a credit balance on the claim. This credit balance will automatically become an un-applied credit, which will be available for posting against other charges or can be refunded back to the patient. In order to use this feature, you must configure Quick-MD with a new CPT Code and two new adjustment codes.

> ***Important:*** *Over-payments from Insurance companies (payments that carry the **I**, **S** or **A** responsibility codes) will remain regular credits, only over-payments that carry the **P** responsibility will become un-applied credits.*

Configuring Quick-MD to handle Un-Applied Credits

To put pre-payment credits in the ledger you must have a CPT record in the CPT codes table to handle them. The Office code and CPT code must be "CREDIT". The description should be something to the effect of "Patient Overpayment or Deposit". *(for more information on adding CPT records see page 43)*

The next step that must be performed is to add two new Adjustment Codes to your Adjustment Table. *(for more information see page 68)*



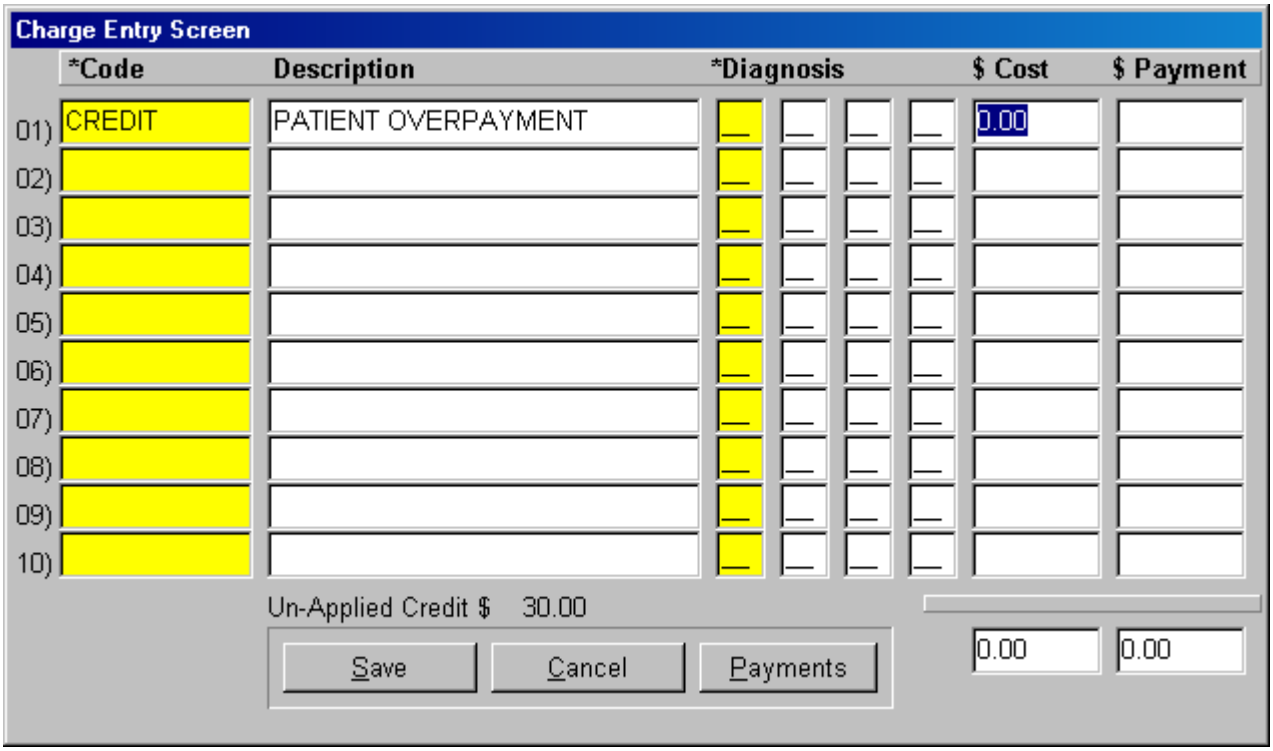
You can see we have added two new entries to the table, entry number 24 and 25. Once this is done you need to tell Quick-MD which entries from the table are to be used to move the un-applied credits into and out of the claims. To do this, simply type the number that corresponds to the Transfer Out code in the appropriate field at the top right of this screen. Then type the number that corresponds to the Transfer In account.

> ***Note****: You can use your standard Transfer In and Transfer Out Codes, but (if you have room) we recommend that you add two new ones that more accurately describe the moving of funds in and out of un-applied credits. For example: Add an adjustment called "FROM UNAPPLIED CREDIT" with a* **-** *for moving money from the un-applied credit accounts. Then add an adjustment code called "UNAPPLIED PYMT TO ACCT." with a* **+** *for applying this money to claims.*

Accepting Un-Applied Credits

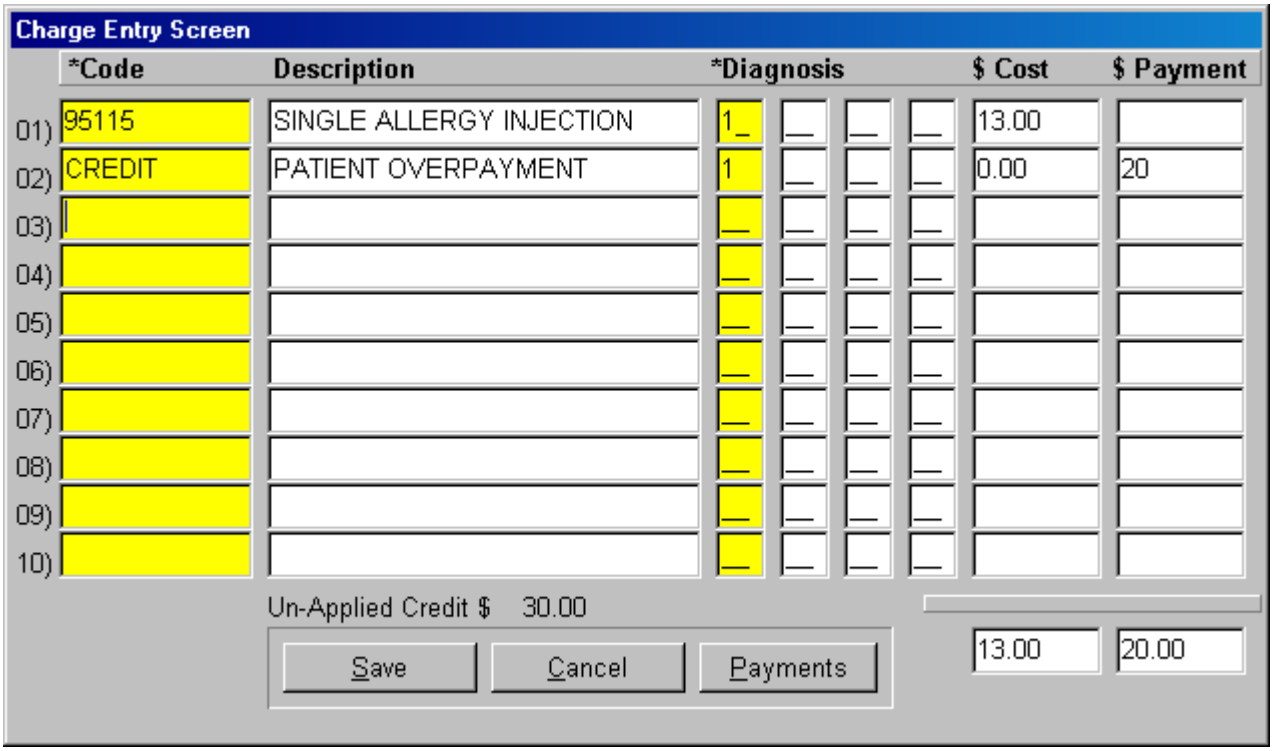
There are two ways to enter un-applied credits in Quick-MD, both of which utilize the Charge Entry Screen.

If you want to simply put an over-payment into the patient's ledger, open up the Fast Charge Entry Screen, Enter Charges Patient Claim. *(for more information see page 213)*



In the ***Code** field type in the CPT Code of CREDIT. Leave the Cost at $0.00 and enter the amount of the credit you wish to apply in the payment field. Then hit **<Save>** and a new claim will be created in the patient ledger that will track and handle the un-applied credit.

The other way allows you to take an Over-Payment at the time of charge entry.



In this case you would enter the charges as normal and then accept any payments against these charges. If the patient gives you a payment that is more than the total of payments applied against each charge, you will pull in the CPT record of CREDIT on the last line and put the balance of the payment into the Payment field. When you **<SAVE>** this charge, it will create an over-payment account for you and place a Note on the current claim that shows you that an over-payment was taken on this claim.

> ***NOTE:*** *If you wish a portion of this payment over payment to be applied to this charge, then enter that amount in the payment field of that charge, and then enter the amount that goes into unapplied credits in the payment field of the Credit entry.*

APPLYING UN-APPLIED CREDITS

Applying a Patients Un-Applied Credits can be done in several different ways.

APPLYING UN-APPLIED CREDITS DURING CHARGE ENTRY

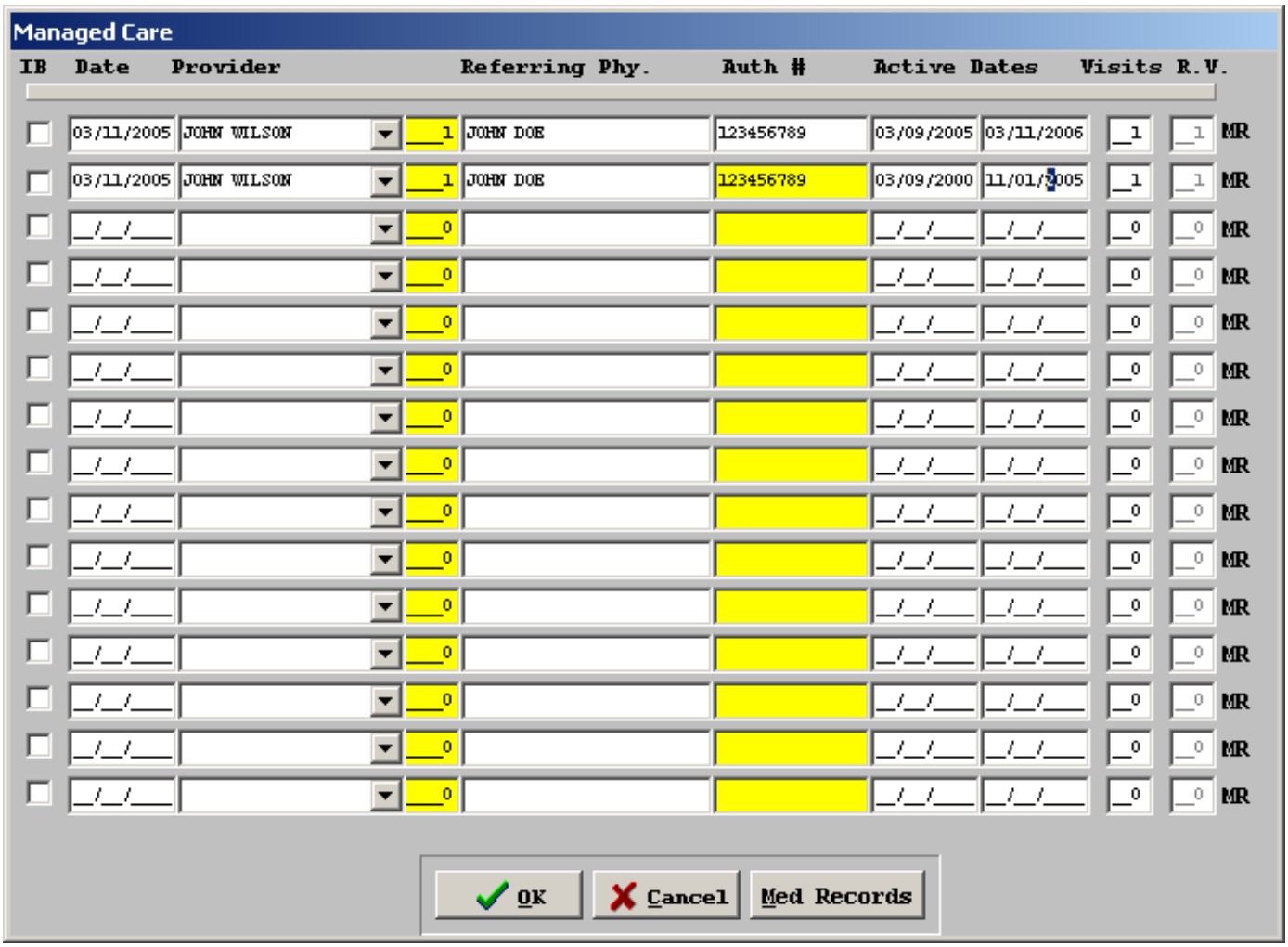
Once the charge entry screen is filled out, you can apply Un-Applied credits to these charges by hitting the Payments button at the bottom of the screen. *(For more information on using the Payments screen see page 168)*

APPLYING UN-APPLIED CREDITS USING THE PAYMENT POSTING MODULES

In any of the Payment Posting Modules, you can apply Un-Applied credits to charges. *(For more information on using the Payment Posting Modules see page 231)*

[MANAGED CARE] - MANAGED CARE MODULE

Use this feature to track up to 15 Pre-Authorization numbers. This Module can be accessed in Quick-MD from the patient's demographics screen, the Supply Form *(for more information see Charge Entry on page 163)* and from the booking screen within Q- Schedule *(for more information page 107)*


Managed Care
IB Date Provider Referring Phy. Auth # Active Dates Visits R.V.
03/11/2005 JOHN WILSON 1 JOHN DOE 123456789 03/09/2005 03/11/2006 1 1 MR
03/11/2005 JOHN WILSON 1 JOHN DOE 123456789 03/09/2000 11/01/2005 1 1 MR
OK
Cancel
Med Records

IB: This is for clients that are using the managed care module for tracking inbound and outbound referrals.

DATE: Date the Pre-Authorization was issued.

PROVIDER: Provider the Pre-Authorization was issued to.

REFERRING PHYSICIAN: <F1> in the yellow field allows you to select a referring physician. **<F10>** allows you to add a referring physician if they are not already in the system.

AUTH#: Enter the Pre-Authorization number here. Hitting the <F1> key will automatically enter the previously used number into this field.

ACTIVE DATES: Starting and Ending Dates of Authorization numbers validity.

VISITS: Number of visits Authorized by the number

RV: Displays remaining visits left as the authorization numbers is used during the charge entry process, the system is counting down.

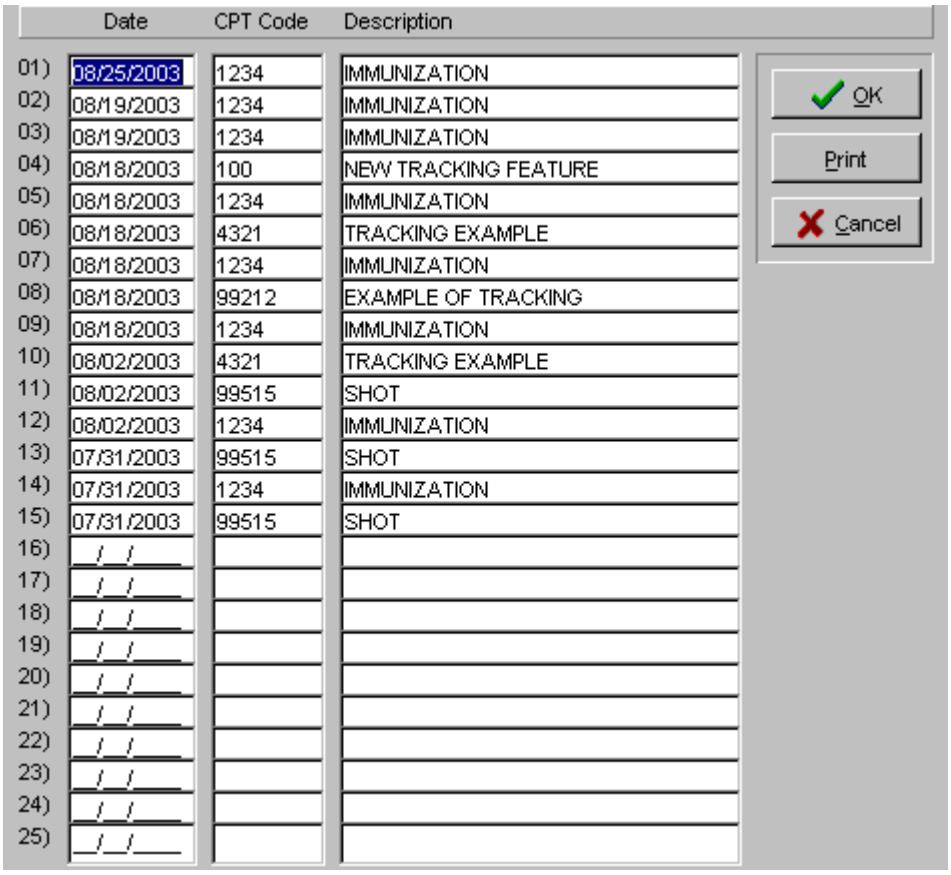
> **NOTE:** During the scheduling process, hit **<F1>** from the booking screen in the yellow **Pre Cert#** field to access the **Managed Care Module**, and double click on the pre authorization number that applies

for this visit. The system will pull both the number and set the referring physician on the booking screen. This information can then be printed on the super bills.
Also during the charge entry process, on the supplier form, you may use the **<F1>** key from the authorization number field to access the Managed Care Module. Double click on the authorization number that applies to this charge, and the system will automatically pull it into supplier form and set the Referring Physician. Quick-MD will count down and display the number of remaining visits in the **RV** field of the Managed Care Module.

MED RECORDS/MR: MED RECORDS will start the medical records interface. If you double click on the **MR** at the end of the line this will start the medical records interface with information carried from that line to the created document. *(for more information see page 193)*

[CPT] – CPT CODE TRACKING

This feature allows you to access all of the tracked CPT codes that have been used on this patient. You can even print a report of this screen by hitting the <Print> button.



ELECTRONIC MEDICAL RECORDS

Quick-MD's Electronic Medical Records is broken down into three functional areas:

1. Attaching Documents to a Patient's File
   (for more information see page 196)

2. Tracking Patient Phone Messages
   (for more information see page 205)

3. Tracking Patient Prescriptions
   (for more information see page 208)

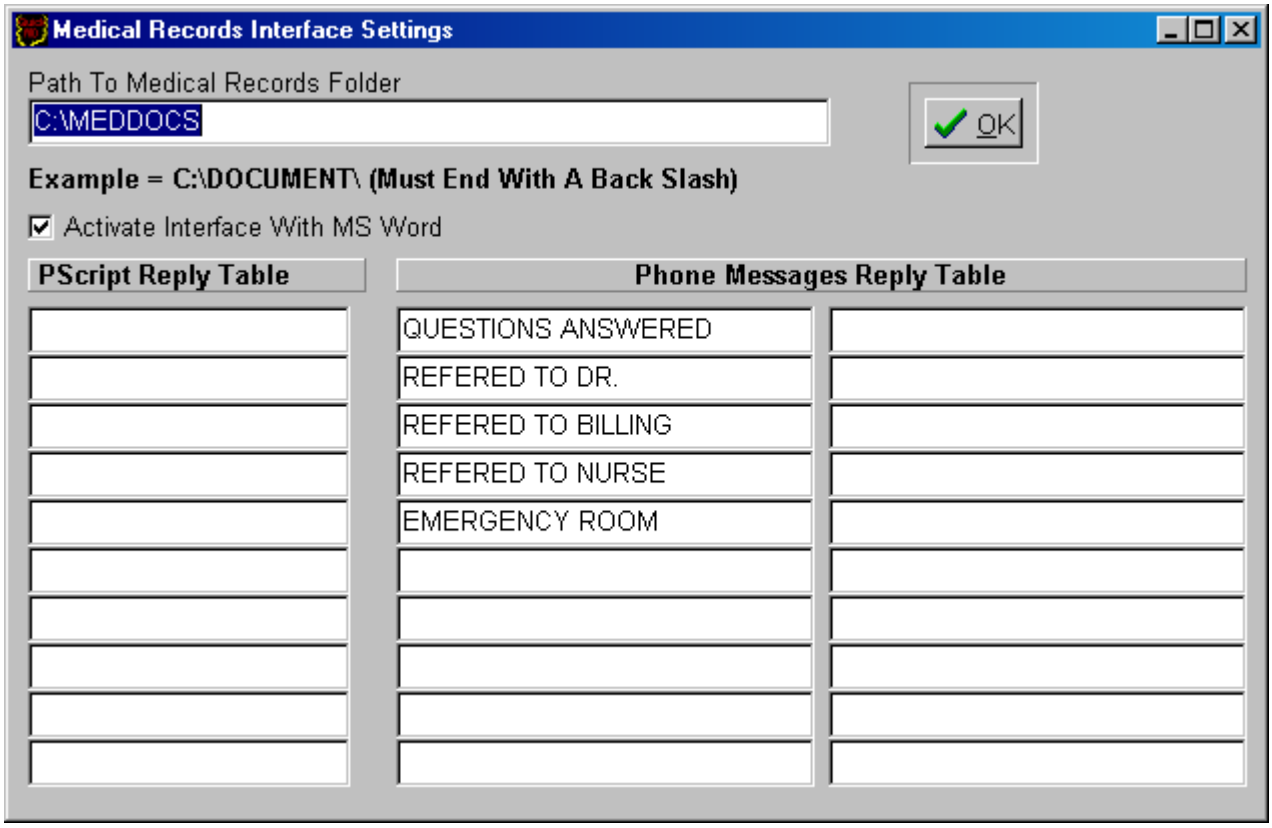
Getting There:
Use the key combination **<Shift>** + **<F1>** while inside the Patient's Demographic Screen to bring up the Medical Records Interface. Or, if you are **Adding a New Operative Transcription** *(for more information see page 196)* to a particular charge in the patients ledger, highlight the charge you wish to attach the Transcription to and then hit **<Shift>** + **<F1>**.



Setting up the Electronic Medical Records Interface

Before you can use Quick-MD's Electronic Medical Records Interface you must make sure that you have Microsoft Word 97 and Windows 98 or later installed on the computer.

You activate and configure the Electronic Medical Records via the Medical Records Settings Found in:
Properties >Misc. defaults > Med Record Settings.

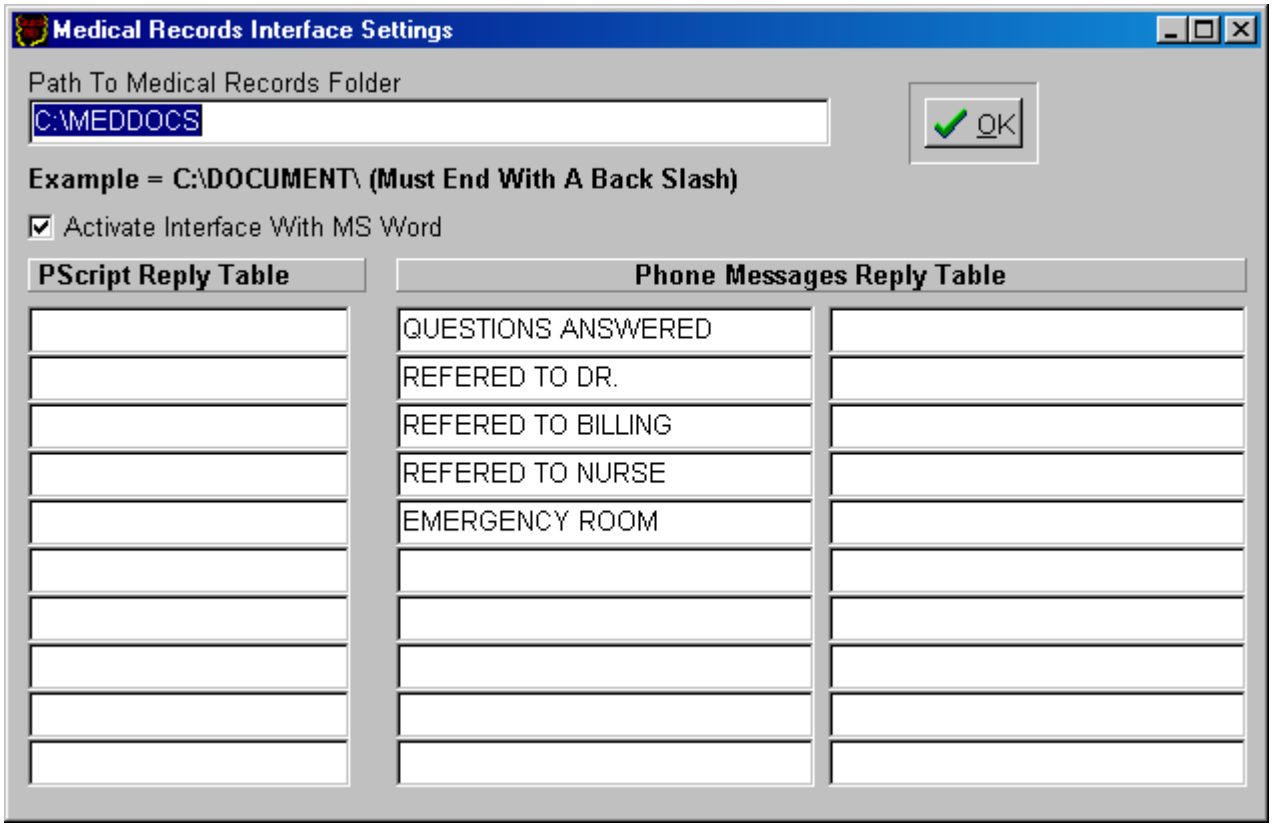


Path to Medical Records Folder – Set the path to your computer where you will store all your Medical Documents.

***Note:** You will also want to set your default directory in MS Word. Inside Word, go to **Tools/Options/File locations** and define to Word where these documents will be stored.*

Activate Interface with MS Word – Click this check box to activate the Medical Records Interface with MS Word.

***Important:** In order to use the Electronic Medical Records Interface, each user will have to have Word 97 or later installed on their local hard drive. Also you will need to go to **System Utilities/Set Operator Rights** and be sure each operator has the rights to use the Electronic Medical Records and its various features.*



Prescription Reply Table – Use this feature to define up to 10 of the most common replies your practice uses when answering patient calls regarding prescriptions.

Phone Messages Reply Table – Use this feature to define up to 20 of the most common replies your practice uses when answering patient calls.

Quick-MD can attach any document created in Microsoft Word 97 or later to your patient's files. This includes scanned documents and images. The key is that all of your patient's documents must be stored in a single directory that Quick-MD has access to and that you carefully utilize the Naming Convention *(for more information see page 201).*

There are two distinct types of documents that you can attach to your patient's files.

OPERATIVE TRANSCRIPTIONS

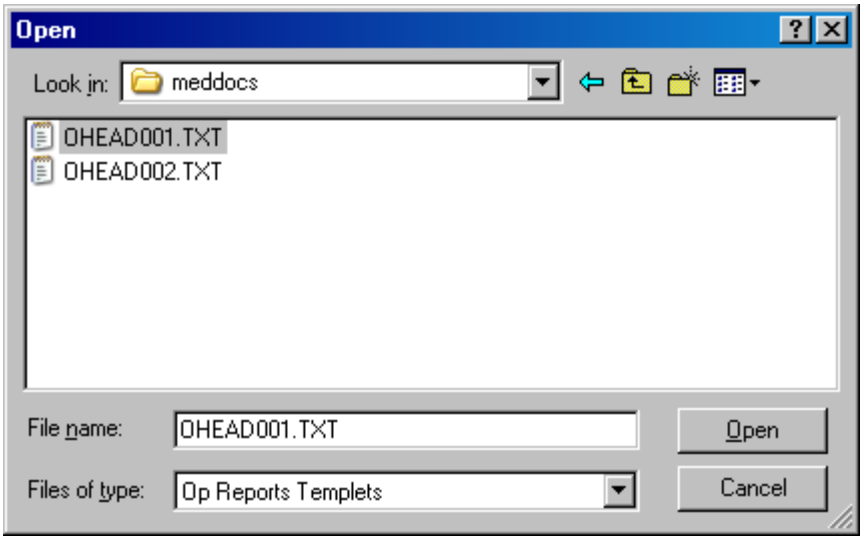
Operative Transcriptions are documents that are attached to specific claims in the Patient's Ledger. These documents are mainly used to create a SOAP note that summarizes one particular visit and details the assessments that led to the generation of that particular claim.

> ***IMPORTANT:*** *You can use Templates to customize your Operative Transcriptions. (for more information see page 199)*
>
> ***NOTE:*** *Even if you are using an outside transcription service, you may still attach the transcription to the claim through the Naming Convention (for more information see page 201) when you save it.*

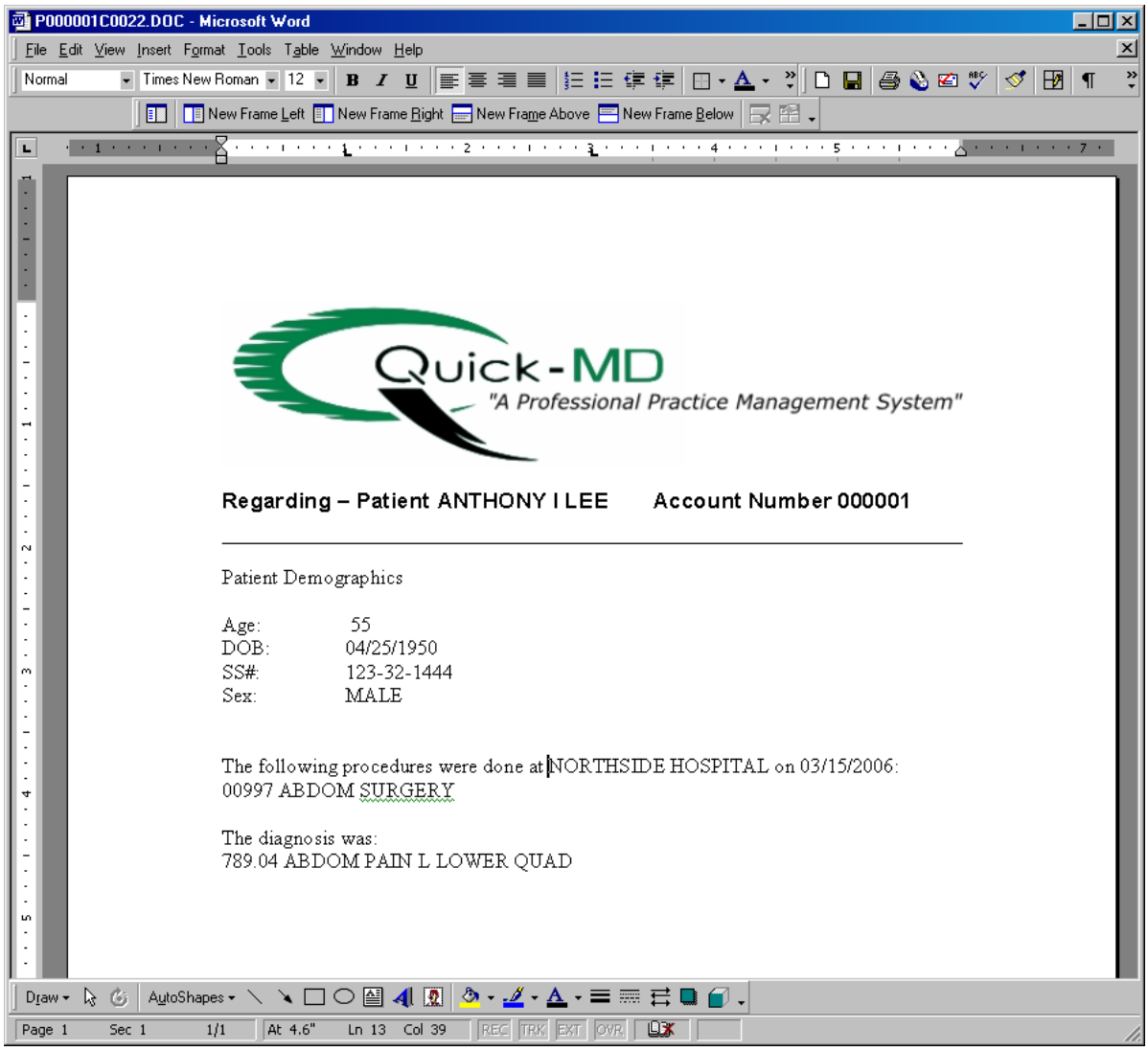
To add **Operative Transcriptions** to a charge, go to the patient's ledger and highlight the claim that you wish to attach the document to. Then hit **<Shift> + <F1>.** Now click **<Add New Operative Transcription>.**



Highlight the Template you wish to use for this Transcription, and click **<Open>**.

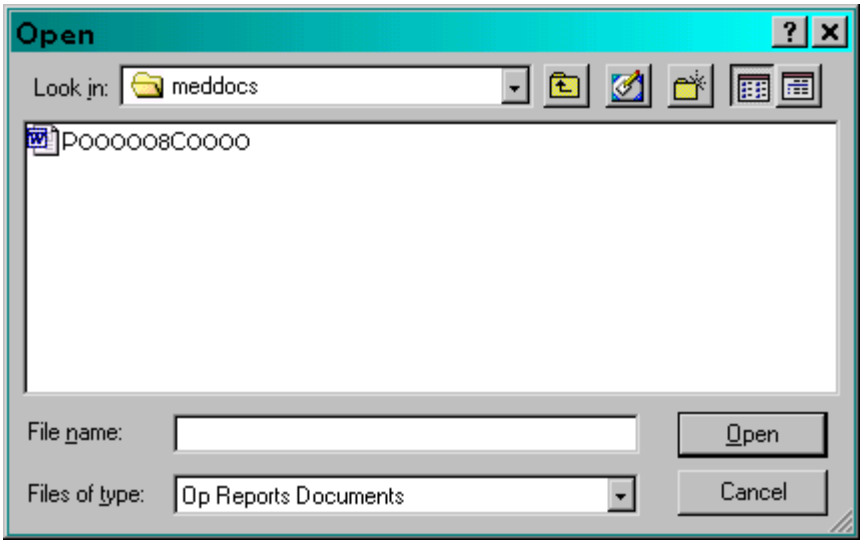

Open
Look in:
meddocs
OHEAD001.TXT
OHEAD002.TXT
File name:
OHEAD001.TXT
Open
Files of type:
Op Reports Templets
Cancel

When the template opens it will automatically bring over all of the patient's information that you have defined and will insert it into the document. When you have finished the document, go to **File**, then click on **Save As**. Be sure that the document is being saved in the Document folder as specified in **Medical Records Settings**. (ie. meddocs) This folder can be set as a default in Word, by going to **Tools/Options/File locations.**


P000001C0022.DOC - Microsoft Word
File Edit View Insert Format Tools Table Window Help
Normal Times New Roman 12
New Frame Left New Frame Right New Frame Above New Frame Below
Quick-MD
"A Professional Practice Management System"
Regarding – Patient ANTHONY I LEE Account Number 000001
Patient Demographics
Age: 55
DOB: 04/25/1950
SS#: 123-32-1444
Sex: MALE
The following procedures were done at NORTHSIDE HOSPITAL on 03/15/2006:
00997 ABDOM SURGERY
The diagnosis was:
789.04 ABDOM PAIN L LOWER QUAD
Draw AutoShapes
Page 1 Sec 1 1/1 At 4.6" Ln 13 Col 39 REC TRK EXT OVR

Reviewing Operative Transcription's

To review **Operative Transcriptions** attached to a charge, go to the patient's ledger and highlight the claim that you wish to review the document for. Then hit **<Shift> + <F1>** to activate the Medical Records interface. Click **<Operative Transcriptions>.** Only the transcription that applies to this claim will appear in the selection box. Highlight the File Name and hit the **Open** button to bring the Operative Transcription to the screen.



OTHER DOCUMENTS

If you can create a document or scan it into Microsoft Word, you can attach it to the patient's file using this feature. **Other Documents** are not attached to specific a Patient Claim, but are attached to the Patient's record as a whole.

There are two distinct ways to create and attach these document types to your patient's files:

Using Templates

You can create an unlimited number of templates for use in Quick-MD. A template is simply a text or word document file that you create in advance that allows you to set-up pre-formatted documents. These templates can be configured to automatically bring over all of the pertinent patient information from the database.

> ***IMPORTANT:*** *The Templates must be placed in the same folder as your patient documents documents.(ie. c:\meddocs) and they must be* ***.TXT or .DOC*** *documents. All Templates are named using the following convention:*

Each of your templates will start with the name OHEAD followed by a description and ending with .TXT or .DOC. For example OHEAD_follow_up.doc is a valid template name. In addition to the custom text that you add, you can use the following insertion commands to bring specific patient information into the templates form the database.

Insertion Commands

Document name will be placed by Quick-MD first line column 1 with the following Insertion commands available for use within the template document. The insertion commands may be used as many times as the operator chooses.
{document name} {calculated by system on add new document button press)

- **Name** - [NAME]
- **Patient's Address** – [ADD]
- **Patient's City State and ZIP** – [CSZ]
- **Acct#** - [ACCT#]
- **DOB** - [DOB]
- **AGE** - [AGE]
- **SS#** - [SS]
- **Sex** - [S]
- **Date of procedures** (taken from the service date on the first charge) - [DATE]

- **Procedure1** (CPT codes will be taken from up to the first 6 charges on claim.) - [CPT1]
- **Procedure2** - [CPT2]
- **Procedure3** - [CPT3]
- **Procedure4** - [CPT4]
- **Procedure5** - [CPT5]
- **Procedure6** - [CPT6]
- **Diag1** (all diagnosis's are taken for the diagnosis's listed on the first charge) - [DIAG1]
- **Diag2** - [DIAG2]
- **Diag3** - [DIAG3]
- **Diag4** - [DIAG4]
- **Location** (taken from the facility set in the supplier form) - [LOC]
- **Medicaid#** - This will insert the patient Medicaid # into the document. - [CAID#]
- **Home Phone** - This will insert the patient's home phone # - [PATPHN]
  [FNAM] If this code is found in the document Quick-MD will ask you to pick a facility. If the [FNAM] is found and the operator selects an entity, then the following 4 codes Will be looked for in the document.
    [FADD] This will insert the entities address.
    [FCSZ] This will insert the entities city, state, zipcode.
    [FPHN] This will insert the entities phone#
    [FFAX] This will insert the entities fax#
- **Today** – [TODAY] Inserts today's date.
- **Patient Balance** – [$PAT]
- **Entire Balance** – [$ALL]
- **Insurance Balance** – [$INS]
- **Martial Status** – [MSTAT]
- **Drivers License** – [DRILIC]
- **Work Phone –** [WRKPHN]
- **Cell Phone –** [CELPHN]
- **Employer –** [EMP]
- **Guardian Name –** [GNAME]
- **Guardian DOB –** [GDOB]
- **Guardian SS –** [GSS]
- **Guardian Phone –** [GPHN]
- **Primary Insured Name –** [INAME]
- **Primary Insured Address –** [IADD]
- **Primary Insured City State Zip –** [ICSZ]
- **Primary Insured Phone –** [IPHN]
- **Primary Insured Relationship –** [IREL]
- **Primary Insured Social Security –** [ISS]
- **Primary Insured Date of Birth –** [IDOB]
- **Primary Insured Employer –** [IEMP]
- **Primary Insurance Name –** [IINS]
- **Primary Policy –** [IPOL]
- **Primary Group –** [IGRP]
- **Secondary Insurance** – [SINS]
- **Secondary Policy –** [SPOL]
- **Secondary Group –** [SGRP]

The next four codes were developed to use with an outbound COMMUNITY CARE REFERAL FORM:

- **Medserv** – [MEDSERV] This code will pop up a box for the user to insert a message into the document.
- **From and To dates** – [FROMDATE] & [TODATE] This will insert the from and to date from the line on the managed care module.
- **Precertification -** [REFNUM] This will insert the precert number from the managed care module.

- **Diagnosis –** [DIAGS] This will pop up a box where the user can enter two diagnoses in and they, along with there descriptions, will print on the document.

EXAMPLE: *Inserting the following line of text into a template would create a new document with the* ***Patient Name****,* ***Date of Birth*** *and* ***Sex*** *auto-inserted by Quick-MD.*

The patient's name is [NAME]. The patient was born on [DOB] and the patient's sex is [S].

Using the Naming Convention

The proper use of the naming convention allows you to easily attach **ANY** document created in Word to your patient's files. Simply open Word and type your document as you wish for it to appear. When you save your document, save it using the following naming conventions:

Operative Transcriptions naming convention: [Example] P000001C0002.DOC
The file name must start with "P" and then must be followed by six digits representing the patient's Account number. A "C" must then follow it and four digits representing the claim number you wish to attach this document to. The file extension must be .doc.

Example: *P000001C0002.DOC*
The above name would be for patient ID# 1 and claim (2)Two in the patient's ledger.

Note: *You can only have one Operative Transcription attached to a claim at a time.*

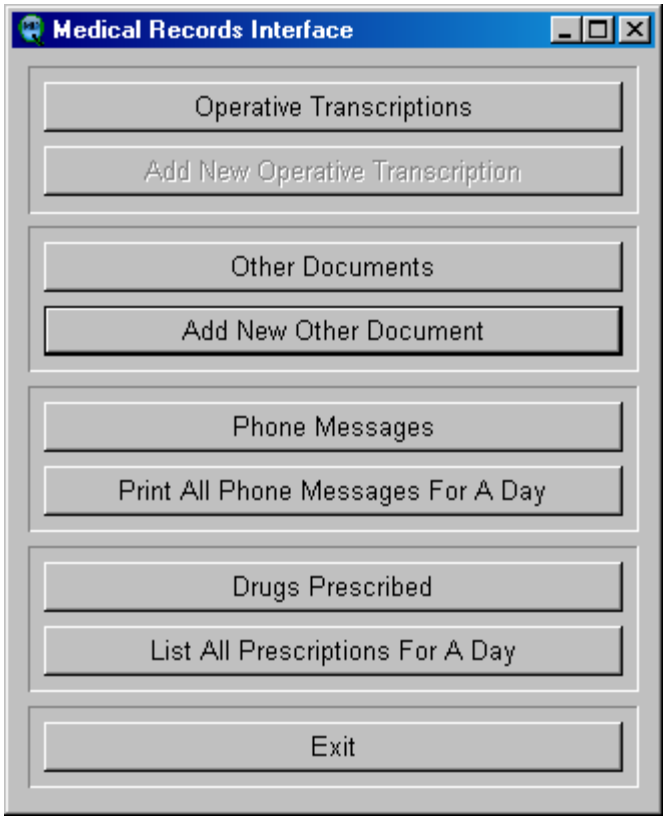
Other Documents naming convention: [Example] P000001D**********.DOC
The name must start with a "P" and then followed by six digits representing the patient's Account number. A "D" must then follow it and what ever the operator wants to enter after the D. The file extension must be .doc.

Example: *P000001D**********.DOC*
*The above name would be attached to patient ID# 1. You can replace the ****'s with any text you wish to identify the contents of the document.*

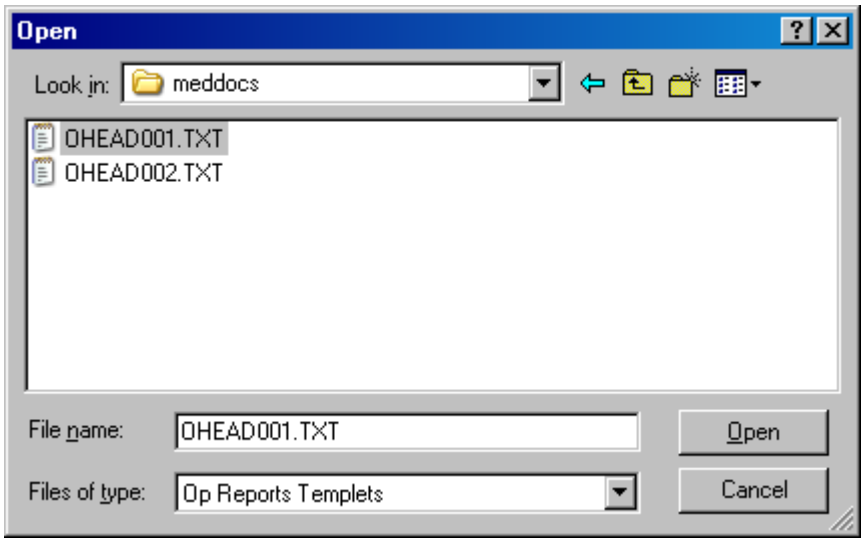
Note: *You can as many Other Documents attached to a claim as you wish.*

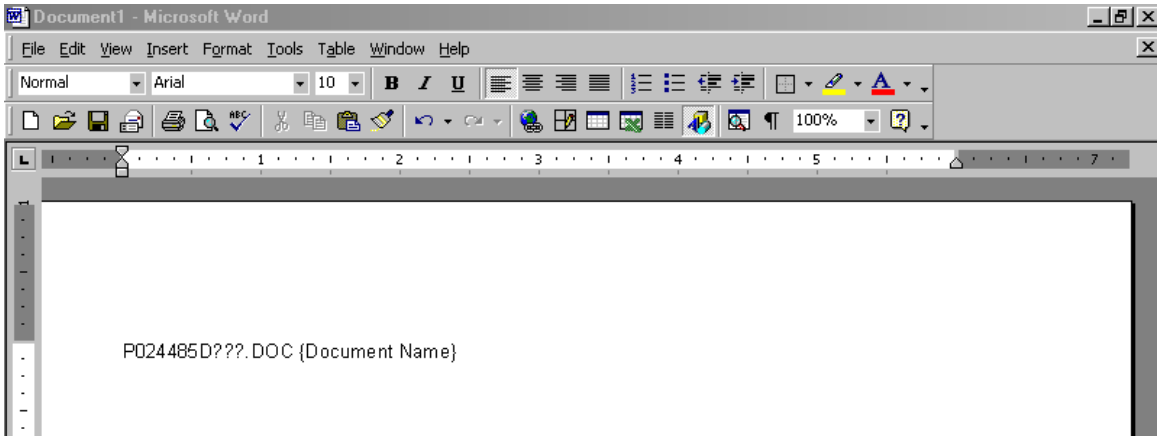
Creating and Attaching Other Documents to a Patient's File

To create a new Other Document, simply open up the Patient's Demographic Screen that you wish to attach the document to. Then hit **<Shift> + <F1>** to activate the Medical Records Interface.



If you want to use a preset template, choose the template from the list and click <Open>. If you wish to create a new document that is not based on a template, click the <Cancel>.





Quick-MD will automatically assign the proper **naming convention** to this document if you opted not to use a template, so that it is readily available to the operator when needed.

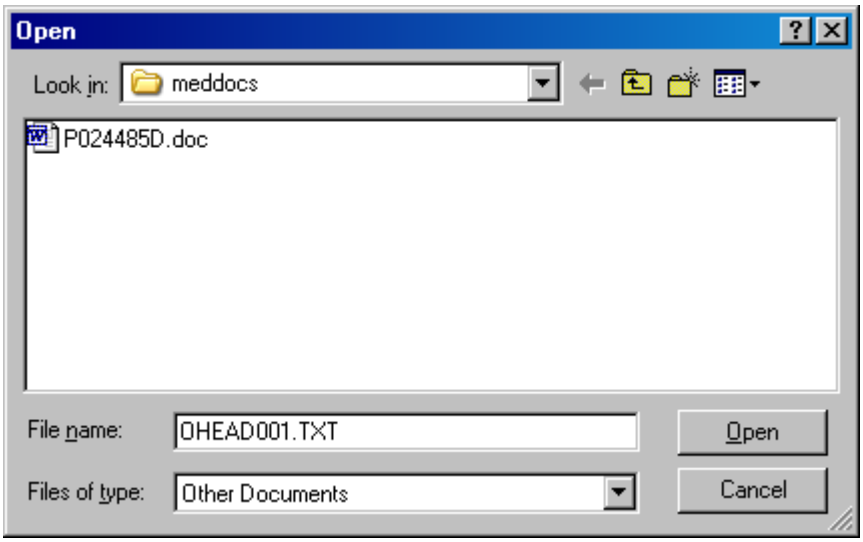
> ***IMPORTANT:*** *Any document may be attached to a patient file. No matter if you are creating a new document, scanning the document in or receiving it as an email, when you hit save your file, name it in the following way: use the letter* ***P*** *followed by the patients* ***6 digit patient ID number****, then the letter* ***D****, followed by something meaningful to you (maybe the date of service) and ending in* ***.DOC****. These documents must be* ***saved*** *in the* ***folder and path defined*** *in* ***Medical Record Settings*** *in* ***Miscellaneous Defaults*** *in* ***Properties****. (for more information see page 96)*

Reviewing/Editing Attached Documents

To access a patient's documents, simply open up the **Patient's Demographic Screen** that you are interested in working with. Then hit **<Shift>** + **<F1>** to activate the Medical Records Interface. Click on the **<Other Documents>** button.

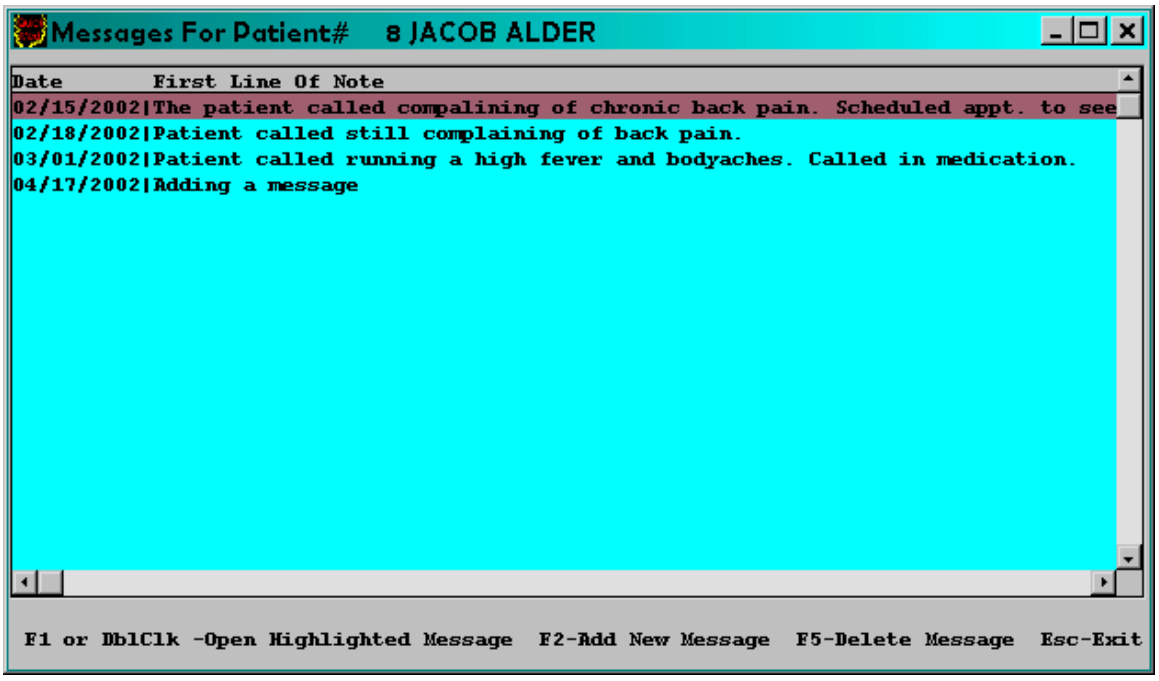


Keep in mind that to get this menu we are at a particular patients demographic screen. So when you click on the **Other Documents** button, **Quick-MD** is going to make ONLY this patient's documents available to you.

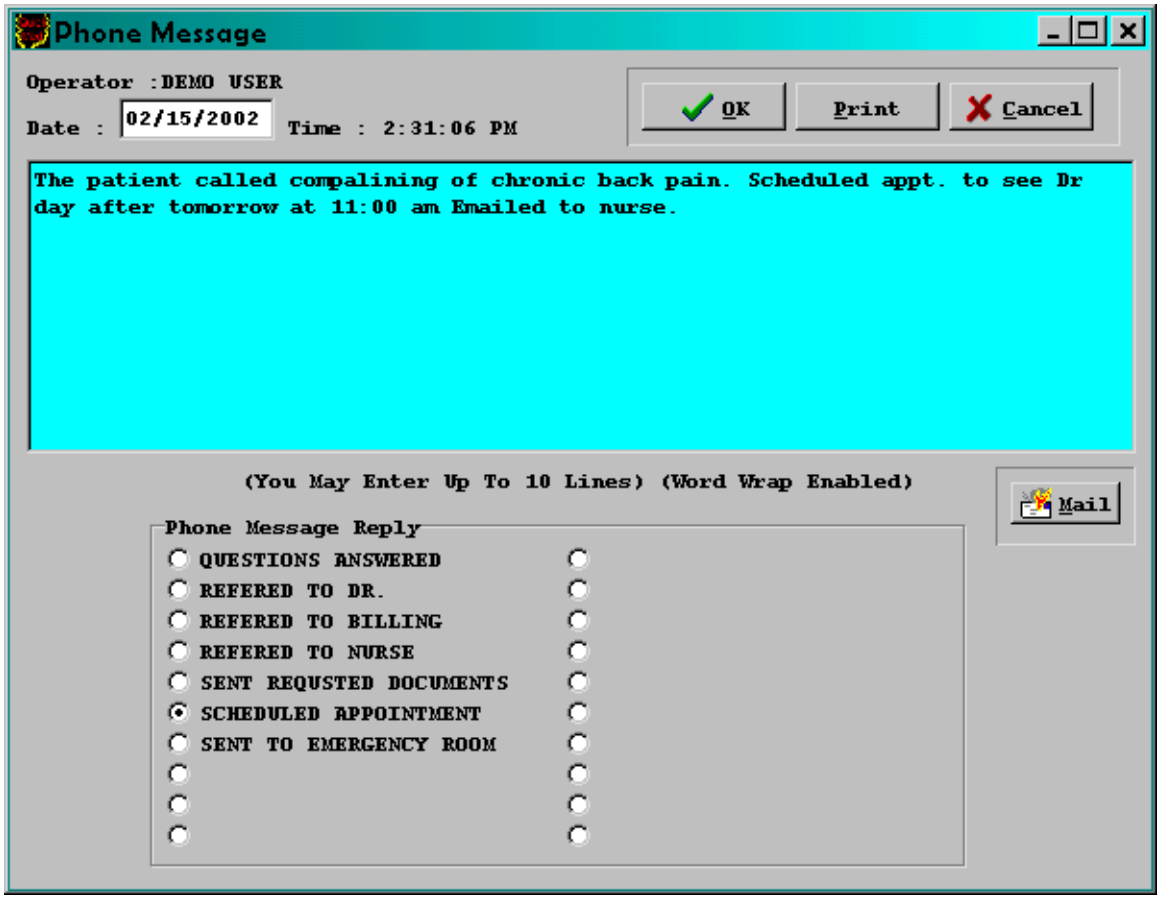


Simply click on the document you want and hit **open**.

Click on the phone message Button.


Messages For Patient# 8 JACOB ALDER
Date First Line Of Note
02/15/2002|The patient called compalining of chronic back pain. Scheduled appt. to see
02/18/2002|Patient called still complaining of back pain.
03/01/2002|Patient called running a high fever and bodyaches. Called in medication.
04/17/2002|Adding a message
F1 or DblClk -Open Highlighted Message F2-Add New Message F5-Delete Message Esc-Exit

The commands are across the bottom of the screen.
<F1> - **opens** the highlighted message. You may also double-click a record to open it.
<F2> - **adds** a new message.
<F5> - **deletes** the highlighted message.

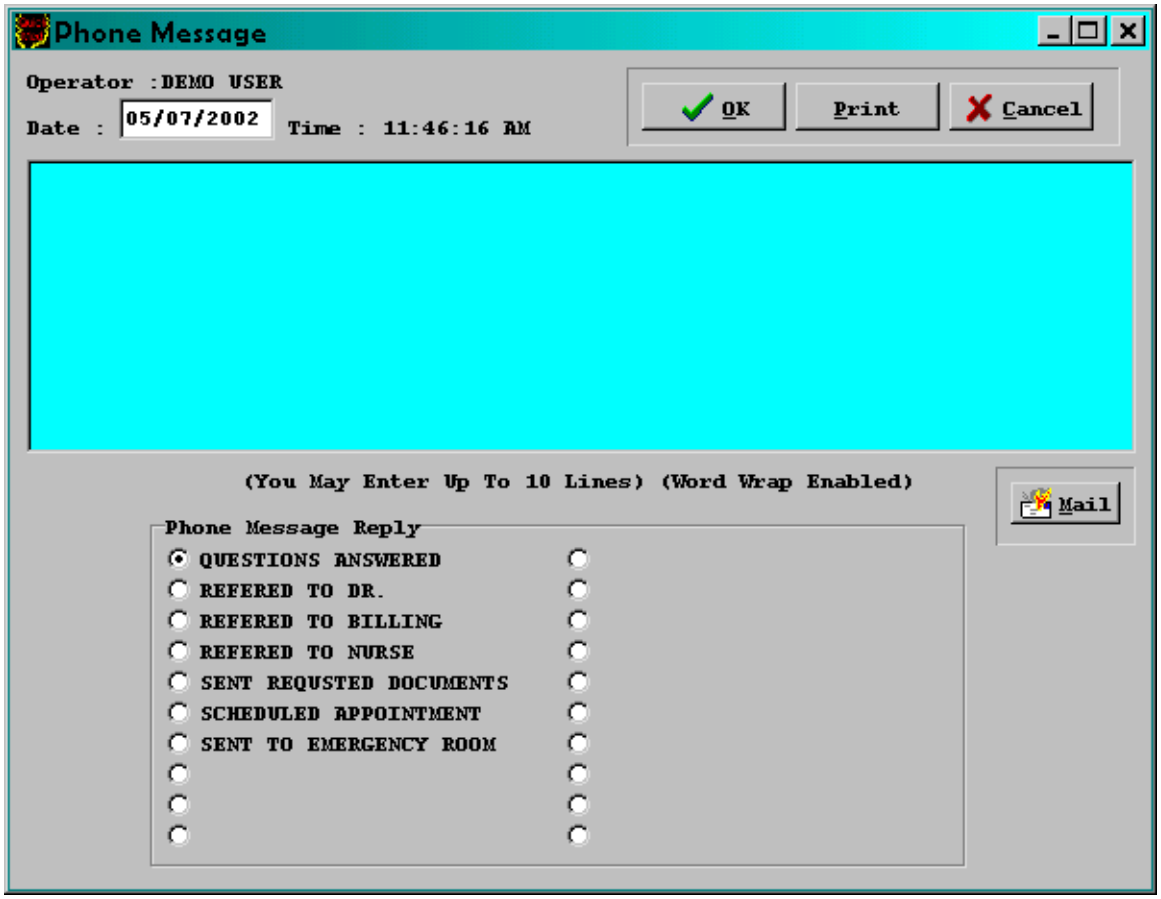

Phone Message
Operator :DEMO USER
Date : 02/15/2002 Time : 2:31:06 PM
OK
Print
Cancel
The patient called compalining of chronic back pain. Scheduled appt. to see Dr day after tomorrow at 11:00 am Emailed to nurse.
(You May Enter Up To 10 Lines) (Word Wrap Enabled)
Mail
Phone Message Reply
QUESTIONS ANSWERED
REFERED TO DR.
REFERED TO BILLING
REFERED TO NURSE
SENT REQUSTED DOCUMENTS
SCHEDULED APPOINTMENT
SENT TO EMERGENCY ROOM

The highlighted message can then be **printed** out or **emailed** to any of the users of Quick-MD on the network.

> **NOTE:** *All phone messages for a day may be printing out at one time by going to any patient demographic screen, hitting* ***<Shift> + <F1>****, and then clicking on the* ***Print All Phone Messages for a Day*** *button.*

ADDING A NEW MESSAGE

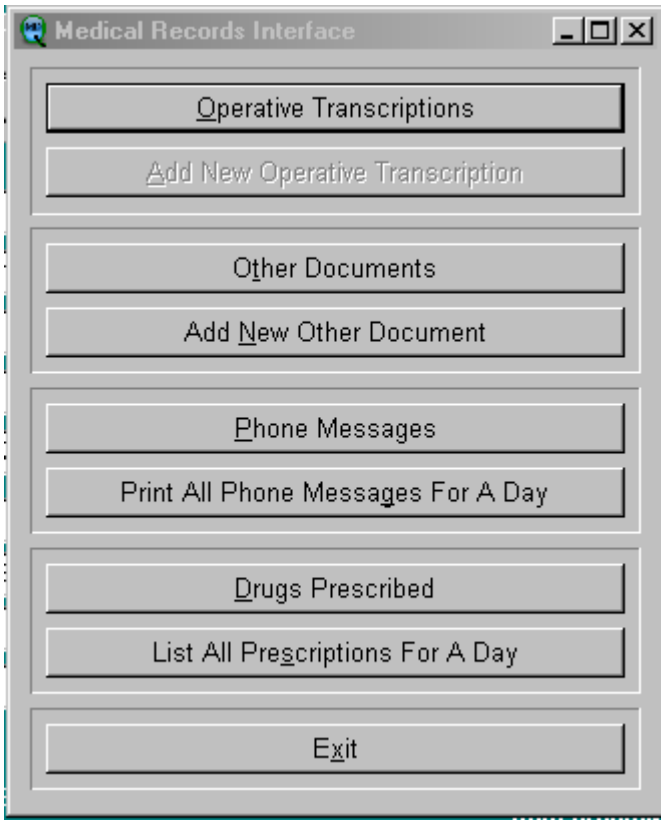
To add a new message, hit **<F2>**

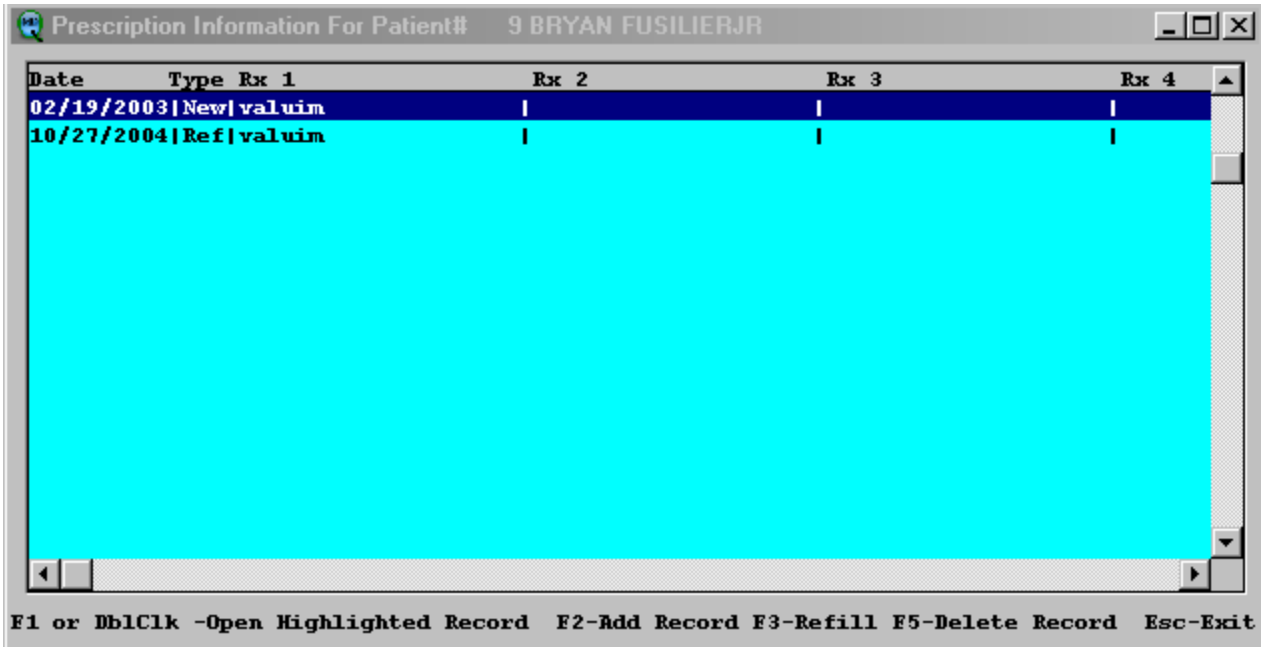


The user may enter up to 10 lines of text and select from one of the top 20 replies (this table is user definable and is in the **Medical Records** settings in **Misc. Defaults** in **Properties.** From here the message may be **printed** out or **emailed** to another user of **Quick-MD**. The Message will now be tracked by the date in which it was entered into Quick-MD.

Tracking and Printing of Prescriptions

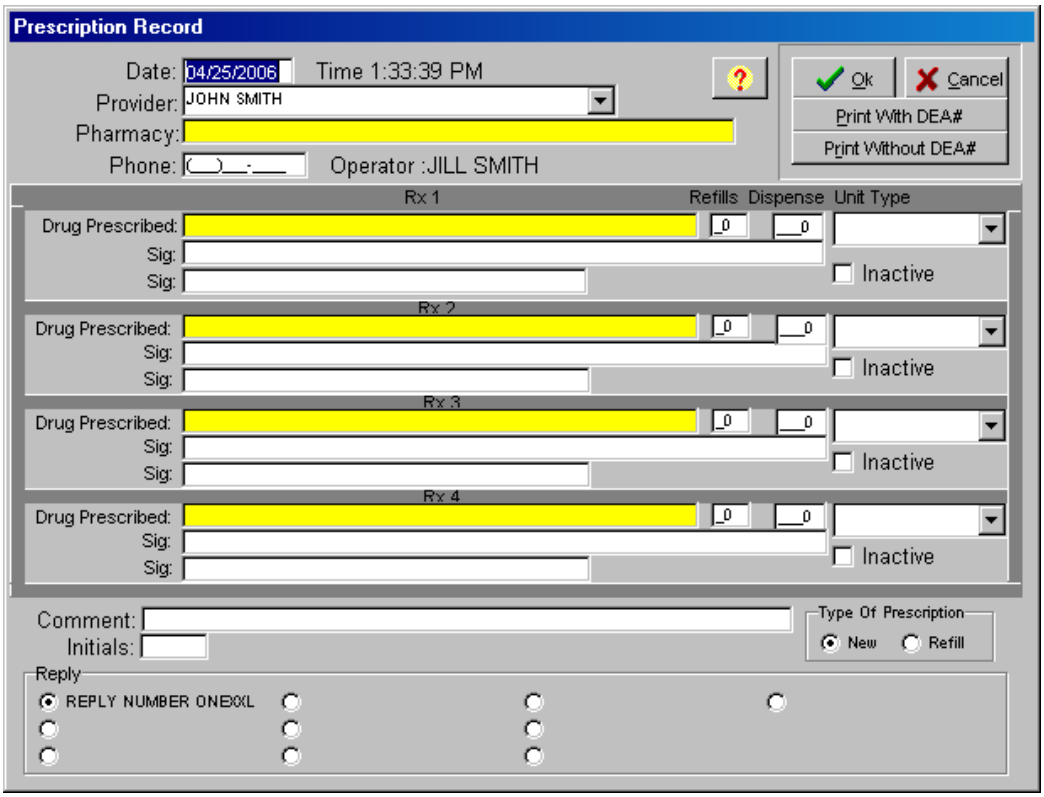
To enter a new Prescription or review past Prescriptions for a patient, go to his demographic screen and hit the **Shift** and the **<F1>** key simultaneously. Then click on the **Drugs Prescribed** button.




Prescription Information For Patient# 9 BRYAN FUSILIERJR
Date Type Rx 1 Rx 2 Rx 3 Rx 4
02/19/2003|New|valuim
10/27/2004|Ref|valuim
F1 or DblClk -Open Highlighted Record F2-Add Record F3-Refill F5-Delete Record Esc-Exit

If you would like to **review a previous prescription**, simply highlight the one you would like to look at and either hit the **<F1>** key or double click on it.

To **ADD A NEW PRESCRIPTION**, simply hit the **<F2>** key.



The date, time, operator, and provider (the one listed in the patient file) will come across as defaults-although all providers in the practice, are an option.

PROVIDER – Select the Provider who is prescribing this drug.

PHARMACY – In the yellow field, the **<F1> key** allows you to browse your **Insurance/FACILITIES TABLES** and bring in the proper Pharmacy. The **<F10>** key allows the operator to add to these tables on the fly.

PHONE – Enter the Patient's Phone Number

DRUG PRESCRIBED – Enter the drugs prescribed. You can enter up to four drugs per prescription. You can setup the drugs you prescribe in the Tables menu and easily bring them into the prescription by hitting F1 in the yellow field. *(for more information see page 61)*

REFILLS – Enter the number of refills.

DISPENSE – Enter the number to dispense.

Unit Type – Enter the unit type. These are custom values that can be set under Properties / Miscellaneous Defaults / Medical Record Setting / Pscript Units of Measurement.

Inactive – Check this box if the drug is inactive.

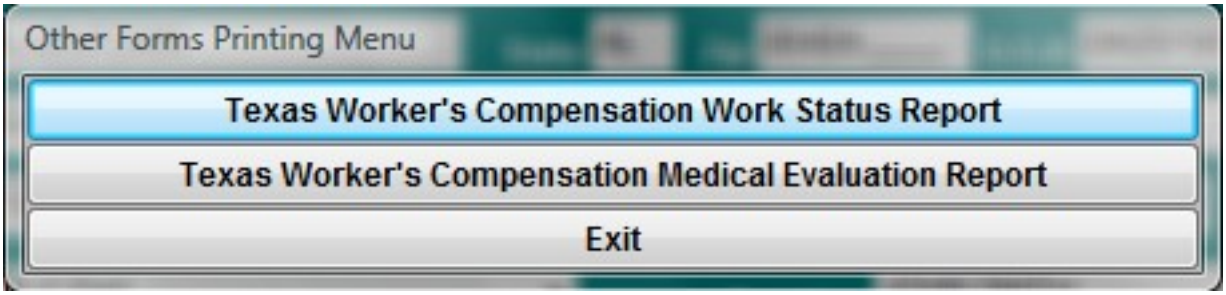
SIG – Enter the instructions for use.

COMMENT – Enter any internal comments here, these will not print on the prescription.

INITIALS – Enter the operators Initials here.

The top 10 reply's to the patient are user definable and this table may be populated in **Medical Records** in **Misc. Defaults** in **Properties** *(FOR MORE INFORMATION SEE PAGE 96)*. The prescription may be printed out ready for signature. All of this patients prescriptions will now be tracked by the date that it was entered into Quick-MD.

[FORMS] – Texas Workers Compensations Forms


Other Forms Printing Menu
Texas Worker's Compensation Work Status Report
Texas Worker's Compensation Medical Evaluation Report
Exit

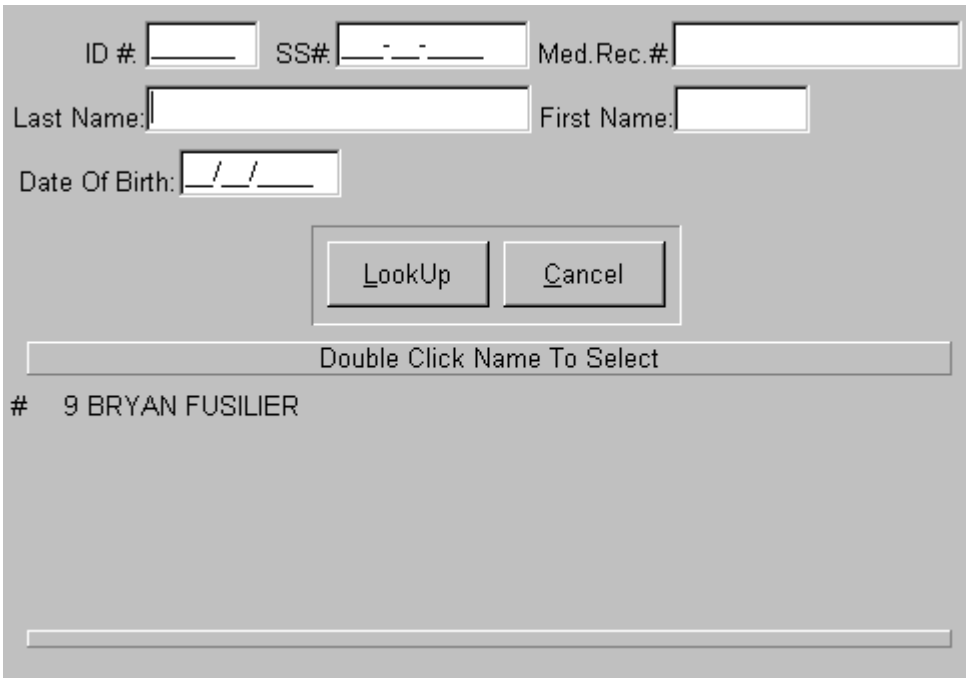
- Texas Worker's Compensation Work Status Report. Clicking on this button will fill out the Texas DWC-73 form.
- Texas Worker's Compensation Medical Evaluation Report. Clicking on the button will fill out the Texas DWC-69 form.

Lookup Patient File

Getting there:



Look Up Patient File Screen



The Patient File can be searched by any of the following fields.

ID# - Patient ID#

Social Security# - Social Security Number

Medical Records# - Medical Records #

Patient Name – Patient's First and Last Name

Date Of Birth – Patient's date of birth

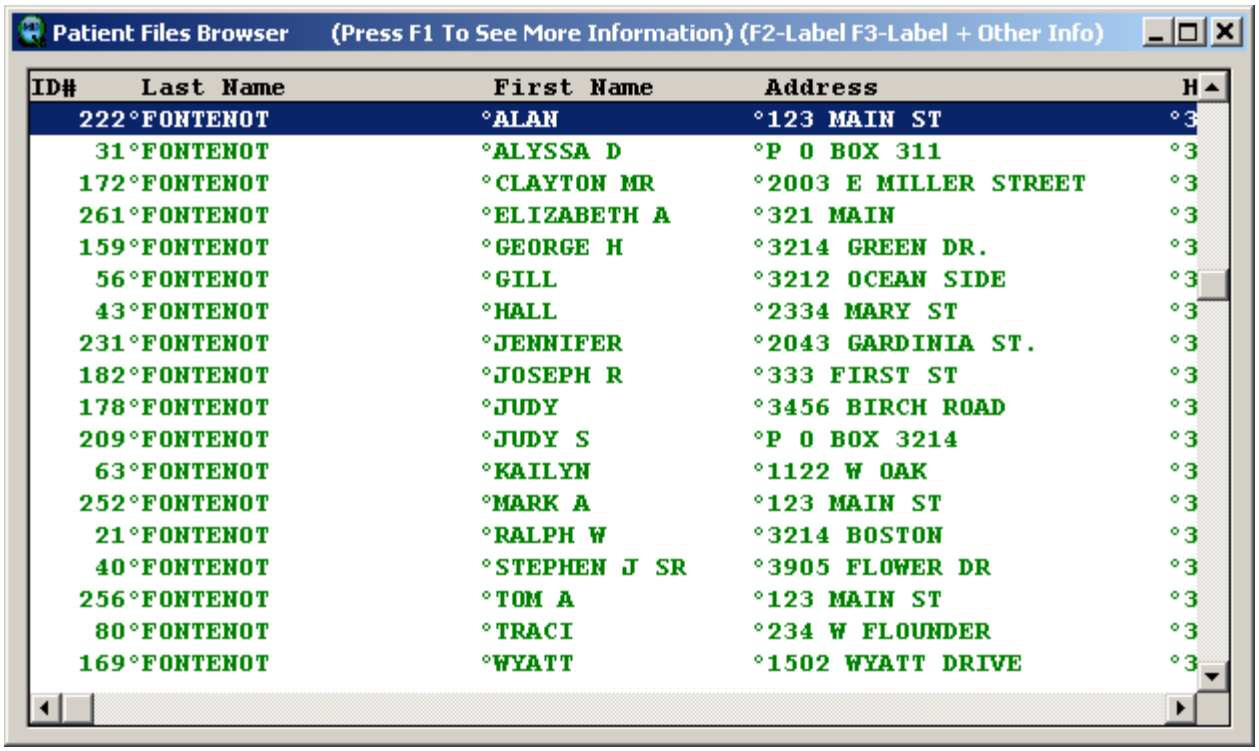
Enter your criteria and then select the **<LookUp>** button to search.

Note: *Quick-MD allows you to choose what field the prompt starts in when looking up patient files. This is set in the* ***Browser Defaults*** *(for more information see page 76).*

Although Quick-MD allows you to set this default, you are still able to look for a patient by any of the other methods. Simply back tab or click on that field and enter the search data.

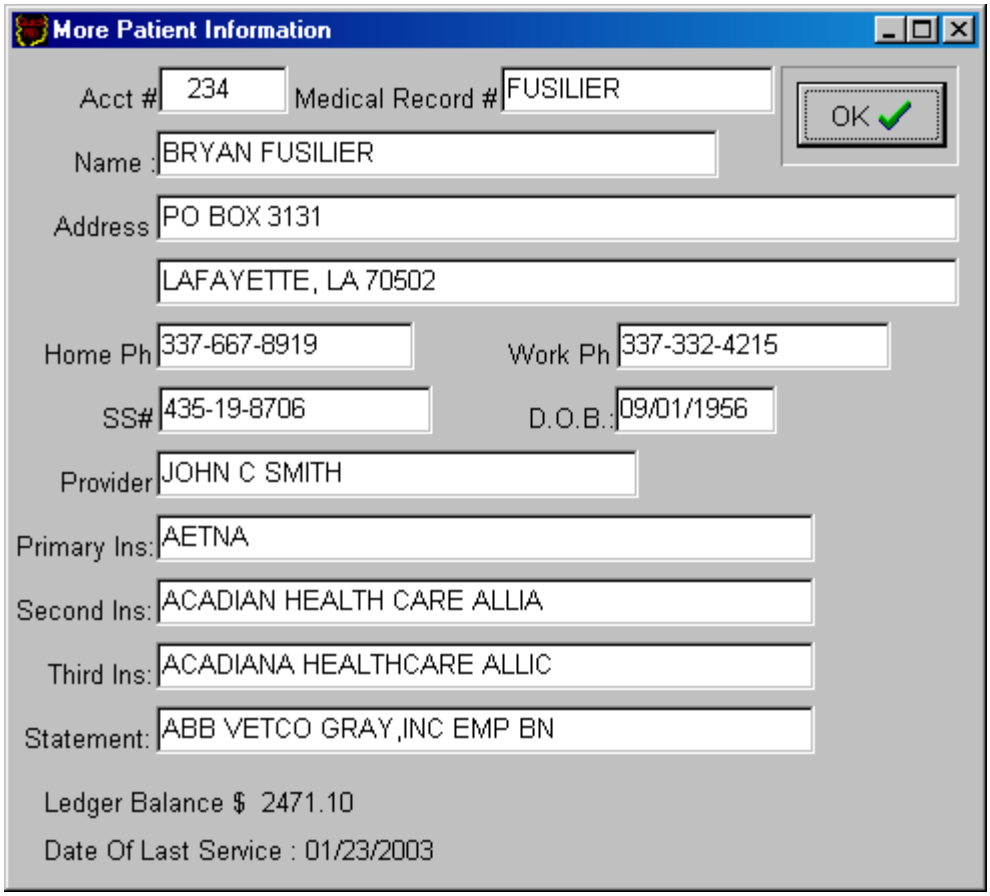
Patient Files Browser

The **Patient Files Browser** allows you to select the appropriate Patient by using your up and down arrow key to highlight the Patient name and press the **<Enter>** button to enter the Patient File.



ID#	Last Name	First Name	Address	H
222	FONTENOT	ALAN	123 MAIN ST	3
31	FONTENOT	ALYSSA D	P O BOX 311	3
172	FONTENOT	CLAYTON MR	2003 E MILLER STREET	3
261	FONTENOT	ELIZABETH A	321 MAIN	3
159	FONTENOT	GEORGE H	3214 GREEN DR.	3
56	FONTENOT	GILL	3212 OCEAN SIDE	3
43	FONTENOT	HALL	2334 MARY ST	3
231	FONTENOT	JENNIFER	2043 GARDINIA ST.	3
182	FONTENOT	JOSEPH R	333 FIRST ST	3
178	FONTENOT	JUDY	3456 BIRCH ROAD	3
209	FONTENOT	JUDY S	P O BOX 3214	3
63	FONTENOT	KAILYN	1122 W OAK	3
252	FONTENOT	MARK A	123 MAIN ST	3
21	FONTENOT	RALPH W	3214 BOSTON	3
40	FONTENOT	STEPHEN J SR	3905 FLOWER DR	3
256	FONTENOT	TOM A	123 MAIN ST	3
80	FONTENOT	TRACI	234 W FLOUNDER	3
169	FONTENOT	WYATT	1502 WYATT DRIVE	3

Note: *Pressing the* ***<F1>*** *key, while a patient's name is highlighted displays detailed patient information. Also,* ***<F2>*** *will print a mailing label and* ***<F3>*** *will print a mailing label with the social security, date of birth, phone number and the patient's id.*



To exit **PATIENT FILES BROWSER** select the **<ESC>** button.

FAST CHARGE ENTRY

This feature allows the user to enter directly into the **CHARGE ENTRY SCREEN** to create a new claim in a patient's ledger without having to go through the patient's demographic screen.

Getting there:

At "Quick Med Main Menu:" Select the **FILE** button
At "drop down menu:" Select **FAST CHARGE ENTRY**



At "LookUp Patient File:" Enter the information you have available on the desired patient, then select the LookUp button to search. This will take you directly to the charge entry screen for this patient. *(For more information on how to use the **CHARGE ENTRY SCREEN** see page 163)*

Open Patient Ledger

Getting there:
At "**Quick Med Main Menu**:" Select the **File** button
At "drop down menu:" Select **Open Patient Ledger**



At "**LookUp Patient File**:" Enter the information you have available on the desired patient, then select the **LookUp** button to search. This will take you directly to the ledger for this patient. *(for more information on the **Patient Ledger** see page 172)*

Delete Patient File

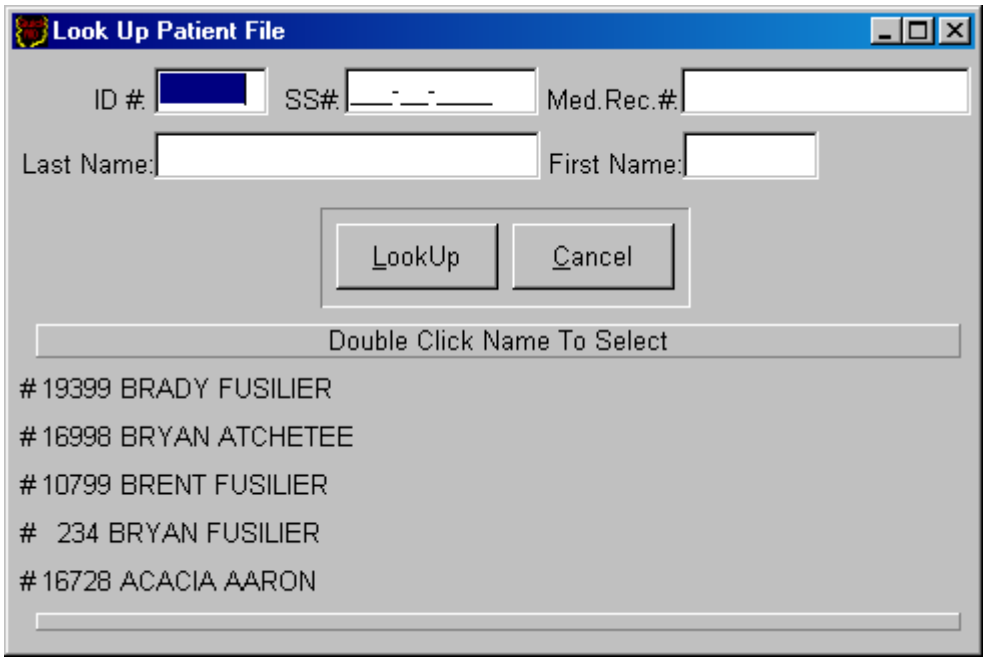
This feature allows you to delete a Patient File, if you have the proper users rights.

***Note:** Quick-MD will not delete a patient file that has ever had an entry in their ledger!*

Getting there:

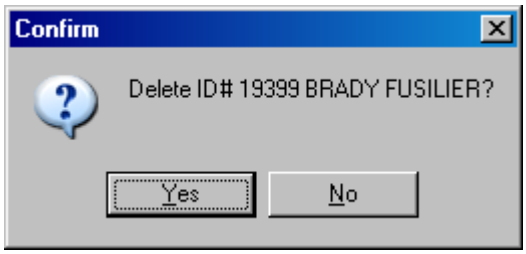
1. At "Quick Med Main Menu:" Select the **File** button
2. At "drop down menu:" Select **Delete Patient File**





At "LookUp Patient File:" Enter the information you have available, then select the **LookUp** button to search
At "Patient Files Browser:" Select the appropriate Patient by using your up and down arrow Key to highlight the Patient name and press the **enter** button to Delete Patient Account

Note: *To see more Patient Information, select the* ***<F1>*** *key. To exit "Patient Files Browser" select the* ***<Esc>*** *button*



At "Confirm:" Select the **Yes** button to confirm deleting process. To "Cancel" deleting process, select the **No** button.

Warning: *When deleting process is confirmed, the complete patient data file will be deleted from memory and cannot be restored.*

Note: *Quick-MD will not delete a patient file that has ever had an entry in their ledger.*

BILLING IN QUICK-MD

How Quick-MD Bills

Quick-MD will go through all patient ledgers and look for claims with balances owed for the chosen responsibility code. If there is no red billing note on the claim then it will be picked up for billing.

Whenever an insurance company or the patient is billed, Quick-MD will place a notation entry in the patient's ledger saying who was billed, when they were billed, and the amount of the bill. These billing notations also have their own invoice numbers. A primary insurance billing notation will have an invoice number of 1000, a secondary insurance billing notation will have an invoice number of 1001, a third insurance billing notation will have an invoice number of 1002, and a patient billing notation will have an invoice number of 1003. Do not delete these invoices. Quick-MD uses them to determine if the responsible parties listed on the claim have been billed.

Quick-MD will consider the claim paid when there is a zero balance on the claim. All claims must reach a zero balance at some time, whether by payment or write off, so post all payments and adjustments to the claim they are intended to pay or adjust.

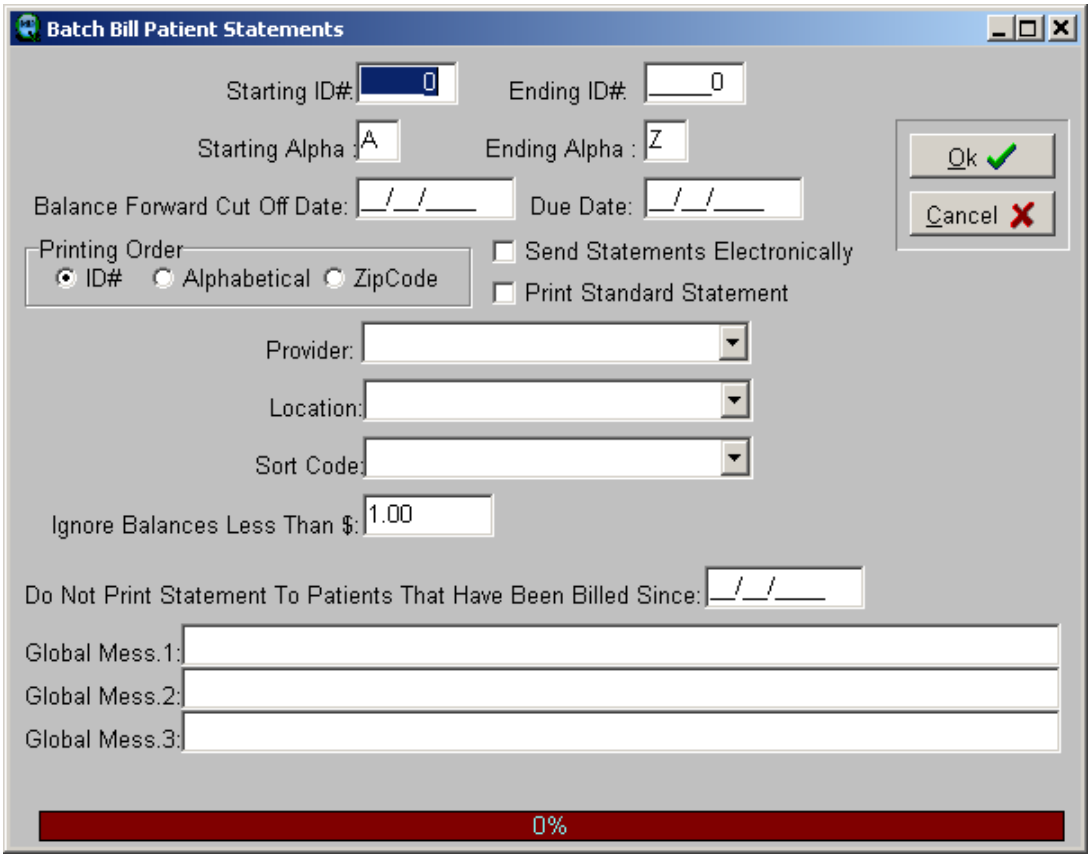
THE BILLING MENU - (Paper Filing)

Patient Statements
Use this feature to generate patient statements based on the criteria you specify.

Getting there:
From Main Menu Select **Billing**
At drop down menu Select **Patient Statements**



The Batch Bill Patient Statement Screen



Starting ID# - enter the account number you want the statements to begin processing. If you want all accounts that are patient's responsibility to process, enter the number 1.

Ending ID# - enter the account number you want the statements to end processing. If you want all accounts that are patient's responsibility to process, enter the number 9 six times.

Balance Forward Cut Off Date - All balances prior to this date will come across as a balance forward on your printed Patient Statements. All balances after this date will be itemized on your Patient Statements. **READ THAT LAST SENTENCE AGAIN!** This allows Quick-MD to only itemize patient account balances as per the wishes of the operator. If you do not enter a date, all patient account balances will come across as a balance forward. Put the date way back for everything to come across as itemized.

Due Date - enter the date payments should be made by.

Printing Order - (ID#) (Alphabetical) (Zip Code) Click in the circle to mark the printing order you want statements to be printed.

Send Statements Electronically - Click the box to insert a check mark ☐, this allows Quick-MD to generate an electronic file that is sent to Pro Bill for statement printing and mailing. To utilize this option, a path and a file name must be set up prior to using.
This maintenance is performed in **Miscellaneous Defaults** *(for more information see page 91)*.

***Note:** If you are printing your own patient statements in-house, leave this option blank.*

Print Standard Statement – Click the box to insert a check mark, this allows Quick-MD to generate a standard patient statement. This can be set as the default option by choosing it in **Other Defaults** *(for more information see page 98)*. Here is an example of the standard patient statement:

DERMATOLOGY CLINIC
429 MAIN ST.
BATON ROUGE, LA 70806
Phone #225-852-5784

Statement Date :04/04/2005
Estimated Ins. Pending $ 0.00
Due Date :04/04/2005

JOHN DOE
7211 W. LEE ST
SULPHUR, LA 70665

REGARDING # 146 JOHN DOE PAGE # 1

REF#	DATE	DESCRIPTION	CHARGES/CREDITS
		BALANCE FORWARD	0.00
0002	04/04/05	OFFICE CONSULT DETAILED	175.00

Current	Over 30	Over 60	Over 90	Over 120	Balance Due
175.00	0.00	0.00	0.00	0.00	175.00

NOTICE:This is a bill. Based upon information from your health plan, you owe the amount shown.

Provider - Use the down arrow key located at the end of the Provider box to select the appropriate Provider statements are to be processed. To have all statements processed for every Provider then do not select a Provider, leave Provider box blank.

Location - Use the down arrow key located at the end of the Location box to select the appropriate Location statements are to be processed i.e.-a satellite location only. To have all statements processed for every Location then do not select a Location, leave Location box blank.

Sort Code -Use the down arrow key located at the end of the Sort Code box to select the Appropriate Sort Code statements are to be processed. To have all statements processed for every Sort Code then do not select a Sort Code, leave Sort Code box blank.

Ignore Balances Less Than - System will default to $1.00. This feature allows Quick-MD to ignore any Patient balance that is less than the amount indicated in this box and statements will not be processed.

Do Not Print Statements To Patients That Have Been Billed Since - If you do not want statements to be processed for Patients who received statements on or after a previous date then enter that appropriate date. To have all statements processed, leave this field blank.

(Global Mess 1) (Global Mess 2) (Global Mess 3) - This feature allows you to enter in three different messages that you want to print on the Patient Statements.

These messages will print on all statements provided they are configured to print on the statements.

> ***Note:*** *If you have Dunning Messages set in* ***Properties/Patients/Patient Dunning Messages****(for more information see page 77), and a patient is late with their payment, the appropriate dunning message will overwrite the global message.*

IMPORTANT*: Make sure that your patient statements are loaded in your printer before selecting <**Ok**>. As the print job does not come to the screen-it goes straight to the printer!*

After all these steps have been completed, Select the button marked **<Ok>** to begin processing and printing then go to step 14. If you do not want statements to be processed, select the button marked **<Cancel>**.

To send Patient Statements Electronically:
Click on the box "send statements electronically"

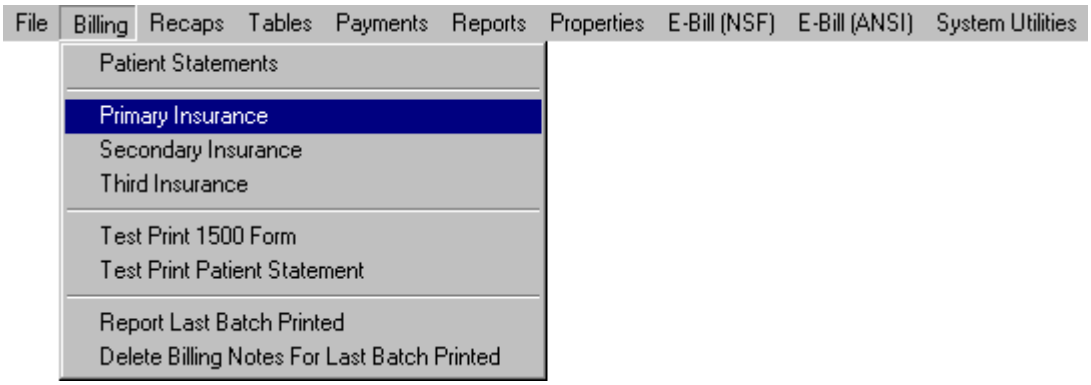
This lays out the electronic file to the path and assigns the file name located in **Properties/Misc. Defaults/Patient statement path.**

Use your communication software to send the file to Pro Bill.

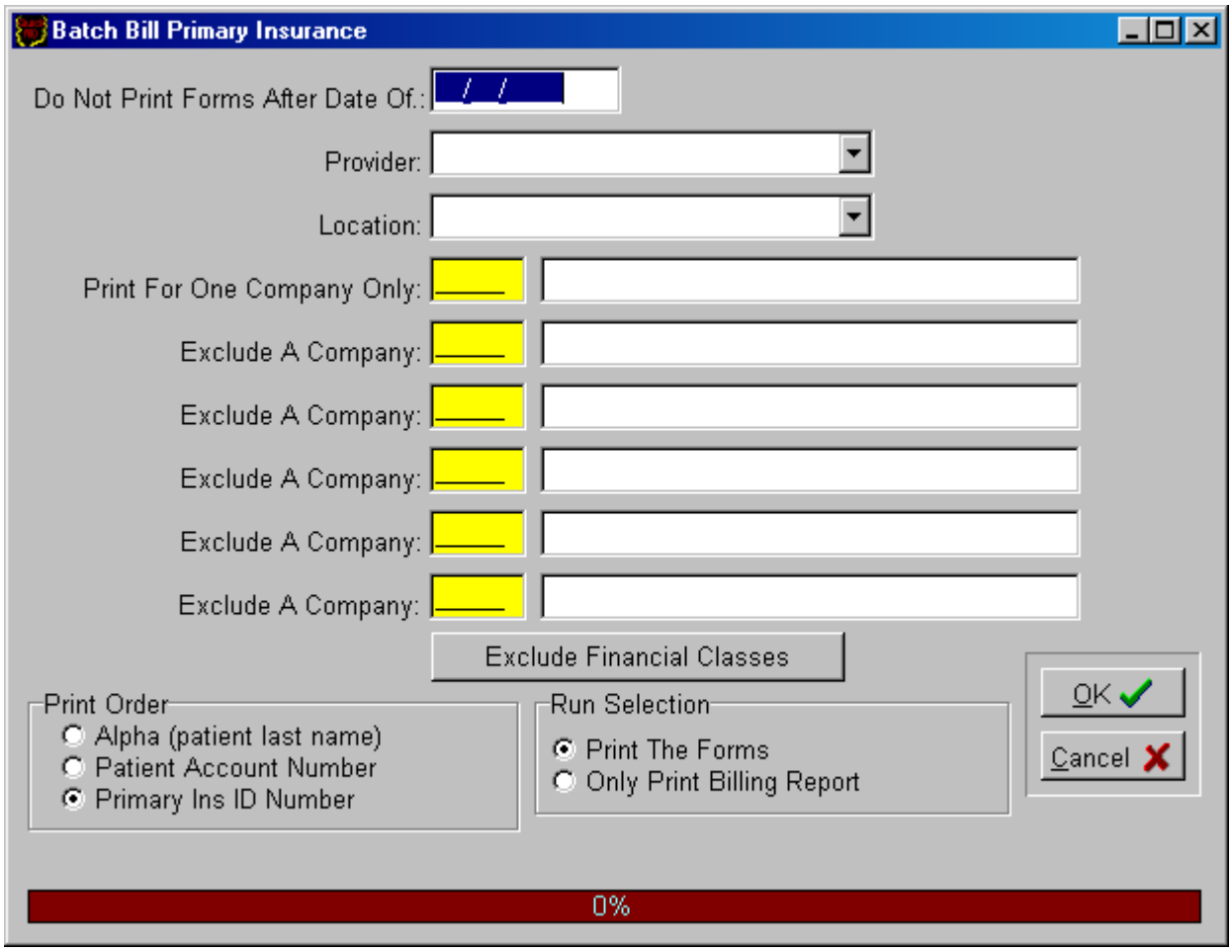
Note: *Pro-Bill will fax an acknowledgement of (Statement Date) (Statement Totals) (Total Statement Amounts). This acknowledgement letter should match your* print out received from step 1.

Primary Insurance
Use this feature to print a batch of HCFA 1500 forms based on criteria you specify.

Getting there:
At "Quick Med Main Menu:" Select **Billing**
At "drop down menu:' Select one of the following: **Primary Insurance**, **Secondary Insurance**, **Third Insurance.**



The Batch Billing Screen



Do Not Print Forms After Date Of - Any claims with a ledger date of service after this date will not be printed

Provider - Use the down arrow key to select the appropriate Provider. To process all claims for multiple Providers, leave field blank

Location - Use the down arrow key to select the appropriate location. To process all claims for multiple Locations, leave field blank

Print For One Company Only - Use this feature to print forms for only one Insurance Company when Insurance ID# is selected

EXCLUDE A COMPANY - Use this feature to select up to five Insurance Companies. Any claims with the Insurance listed in these fields will not be printed.

PRINT ORDER - Use this feature to select the order forms are to be printed. To make a selection, click the circle to insert a mark. ID order prints by Insurance Company ID# order.

RUN SELECTION

PRINT THE FORMS – Use this feature to send the claims directly to the printer.

ONLY PRINT BILLING REPORT – Use this feature to run a pre-billing report of claims to be billed.

Select the **<OK>** button to process. Select the **CANCEL** button to exit without processing.

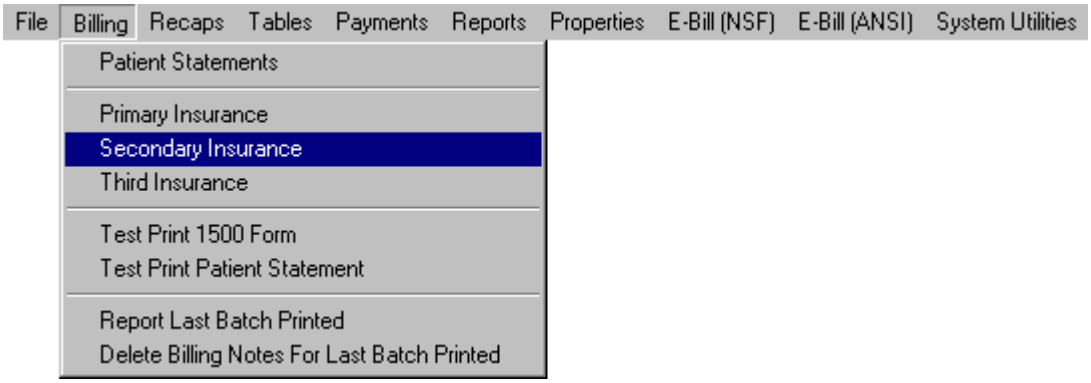
SECONDARY INSURANCE

Use this feature to print a batch of HCFA 1500 forms based on criteria you specify.

Getting there:

At "Quick Med Main Menu:" Select **BILLING**

At "drop down menu:' select one of the following: **PRIMARY INSURANCE**, **SECONDARY INSURANCE**, **THIRD INSURANCE**.



Secondary Insurance claims are selected and printed exactly like Primary Insurance Claims *(for more information see page 219)*

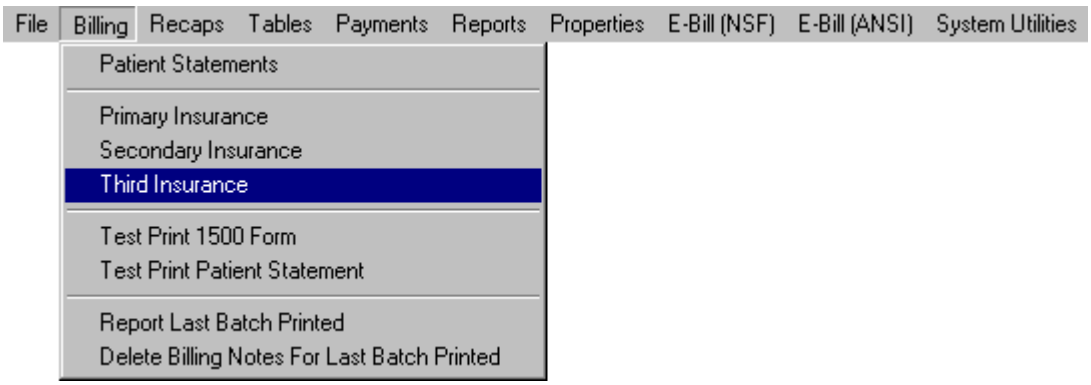
THIRD INSURANCE

Use this feature to print HCFA 1500 forms for your claims that have been reassigned to the third insurance("A" responsibilities).

Getting there:

At "Quick Med Main Menu:" Select **BILLING**

At "drop down menu:' Select one of the following: **PRIMARY INSURANCE**, **SECONDARY INSURANCE**, **THIRD INSURANCE**.

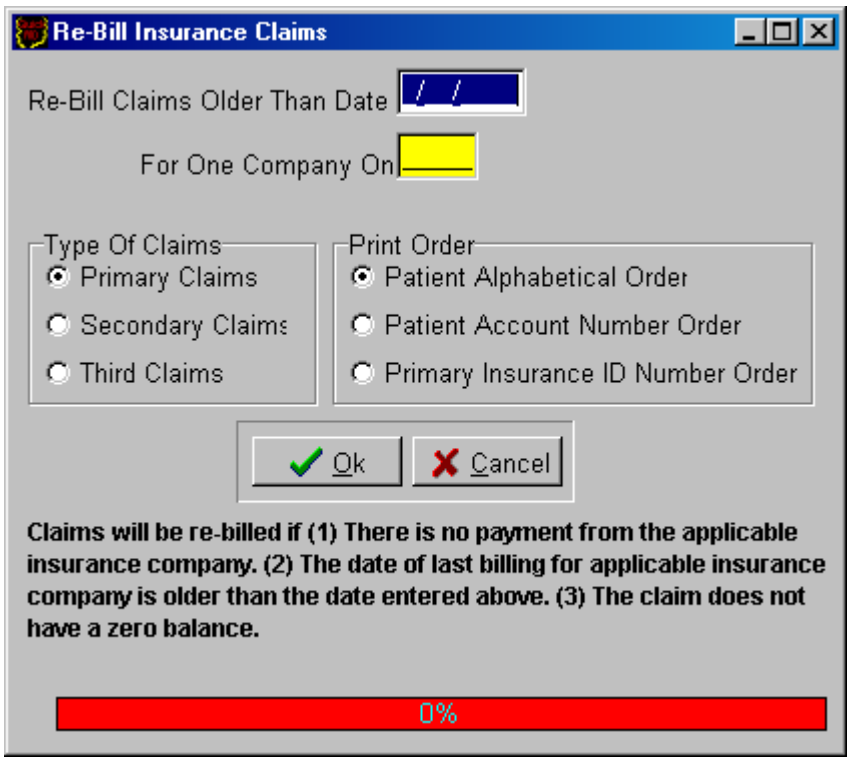


Third Insurance claims are selected and printed exactly like Primary Insurance Claims *(for more information see page 219)*

REBILL CLAIMS

To re-bill claims, simply enter the date that you want claims older than that date to re-bill. Select your parameters, put your 1500 forms in the printer, and click OK.

> ***NOTE:** Quick-MD is using the date on the existing red billing note to determine which claims to re-bill.*


Re-Bill Insurance Claims
Re-Bill Claims Older Than Date
For One Company On
Type Of Claims
Primary Claims
Secondary Claims
Third Claims
Print Order
Patient Alphabetical Order
Patient Account Number Order
Primary Insurance ID Number Order
Ok
Cancel
Claims will be re-billed if (1) There is no payment from the applicable insurance company. (2) The date of last billing for applicable insurance company is older than the date entered above. (3) The claim does not have a zero balance.
0%

REPORT LAST BATCH PRINTED

Use this feature to run a report of the last Batch of Insurance Claims run.

DELETE BILLING NOTES FOR LAST BATCH PRINTED

Use this feature to delete the billing notes that were posted to the ledgers during the last Batch of Insurance Claims run.

> ***NOTE:** This feature is used when there was a problem with the last batch run, ie. Printer jam, where you need to re-start the run.*

THE E- BILL MENU (ELECTRONIC FILING)

Use this feature to file your electronic claims. Filing electronically consists of several steps that we have broken down below.

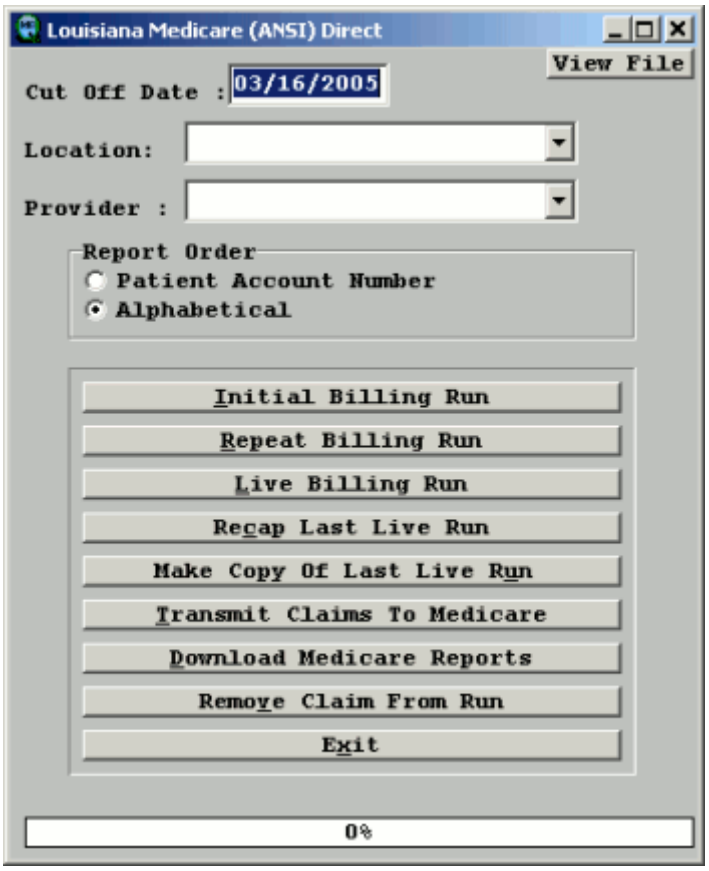
Getting there:

From Main Menu Select **ELECTRONIC BILLING**
Select the appropriate **BILLING OPTION**



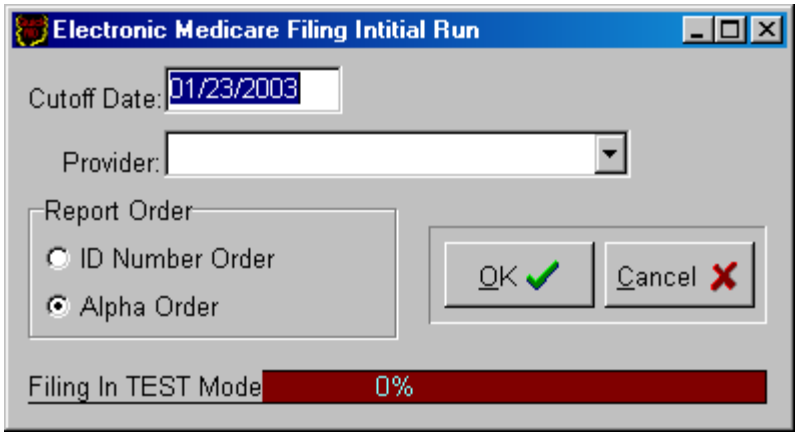
E-BILLING MEDICARE, MEDICAID, LOUISIANA BLUE CROSS BLUE SHIELD AND OCHSNER

The steps for filing electronically to any company are all the same. You simply pick the company you are interested in filing to and follow the steps laid out below.



STEP 1.

Select **INITIAL BILLING RUN.** This tells Quick-MD to look through all patient ledgers for claims with no red billing notes that has the payer set as primary insurance that you have selected to bill.

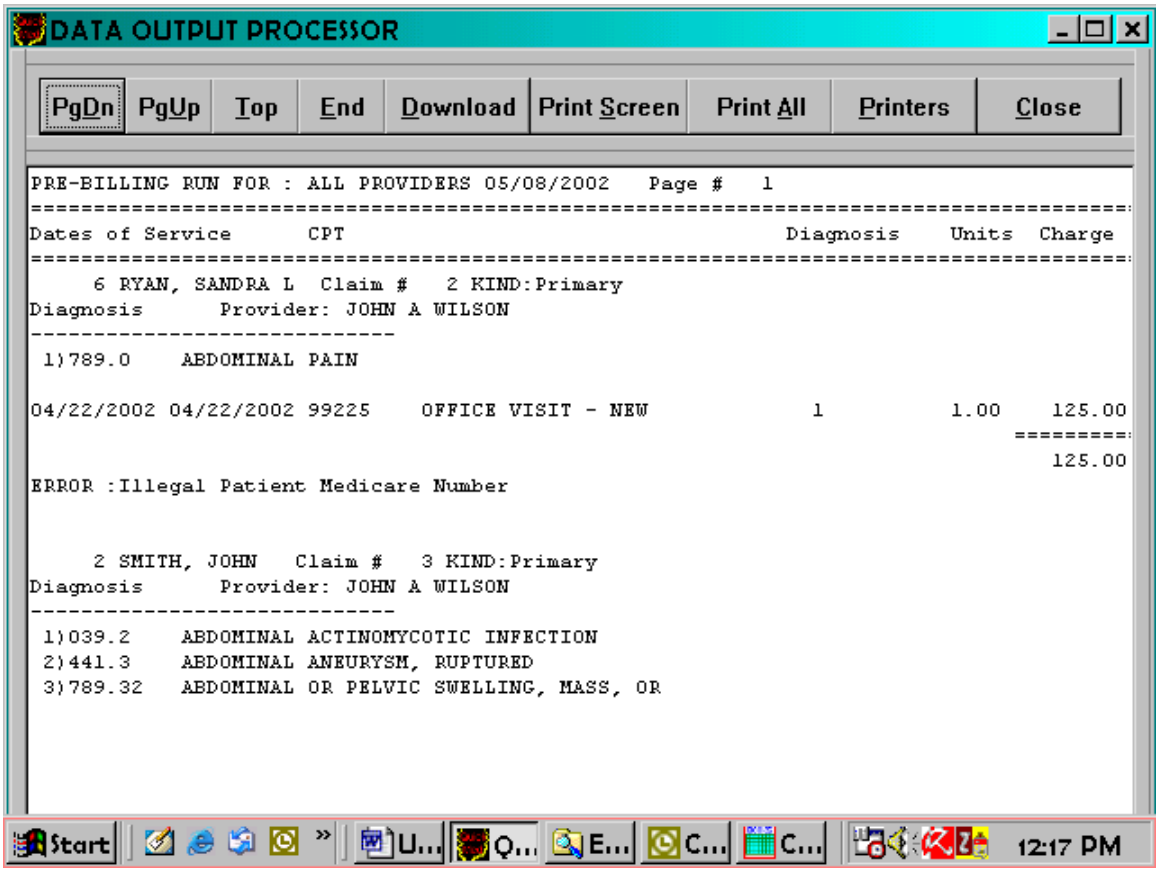


DATE, the date entered will be the cutoff date and any claims with a ledger date after the cutoff date will not be processed.
PROVIDER select the **DOWN ARROW BUTTON** to display Provider name OR leave blank for all Providers.

Select **<OK>**

Select **END** to go to the end of the report to check and see if batch is ready. If the batch is not ready for transmission Quick-MD will read "Error(s) batch not ready for transmission". Select **<CLOSE>** and go to **step 2.** If batch is ready for transmission, select **<CLOSE>** and go to **step 3.**

STEP 2.
Select **REPEAT BILLING RUN**



When the repeat run is selected, only claims with errors will show up on the report!
Select **PRINT ALL** to print all pages to correct errors

> **NOTE***: If claim information that is needed to correct an error is unavailable, and you would like to go ahead and send the run anyway, then select Remove claim from Run: "Input Patient ID#" and "Claim#" located on Pre-Billing Run Sheet. Select* **<OK>**.

After all errors have been corrected, select **REPEAT BILLING RUN**. System should read "No Errors Found - Batch Ready for Transmission". If errors still exist, take necessary steps to correct and repeat **REPEAT BILLING RUN**. **Once all errors are corrected, you are ready to do the Live Run.**

> ***IMPORTANT:*** *DO NOT RUN "INITIAL BILLING RUN" AGAIN. If initial billing run picks up a claim that you do not want to transmit for whatever reason, go to "Remove Claim From Run" button. This feature removes this claim from the electronic batch but DOES NOT REMOVE THE CLAIM FROM THE PATIENT LEDGER. You must run the live billing run after you run "Remove Claim From Run".*

Select **CLOSE** to return to **BILLING MENU**

Step 3.
Select **LIVE BILLING RUN**
At **START LINE RUN***?* Select **YES**
At **PRINT PAPER CLAIM***?* Select **NO**, if you do not want a hard copy for the file.
At **PUT BILLING NOTES***?* Select **YES**
(Quick-MD will then put a red billing note in the patient ledger, which tells the system that the claim was billed and the date billed.)

Note: *This live run stays in Quick-MD till you run another Initial run, which then overwrites the last Live Run.*

Step 4.
Select **Recap Last Live Run**
At **Print Recap of Last Live Run**? Select the button marked **Yes**
Select **Print All** to print Submission Recap

Step 5.
Select **Make of Copy Last Live Run to Disk**
This will make a copy of the last live billing run and place it inside of your ebackup folder.

Step 6.
Select **Transmit claims to Insurance Company**
At this point a blank screen will be displayed while Quick-MD calls the insurance company.
Once a connection is made the computer will fill out the required information and upload the batch file.
After your file is finished uploading, exit out of the window.

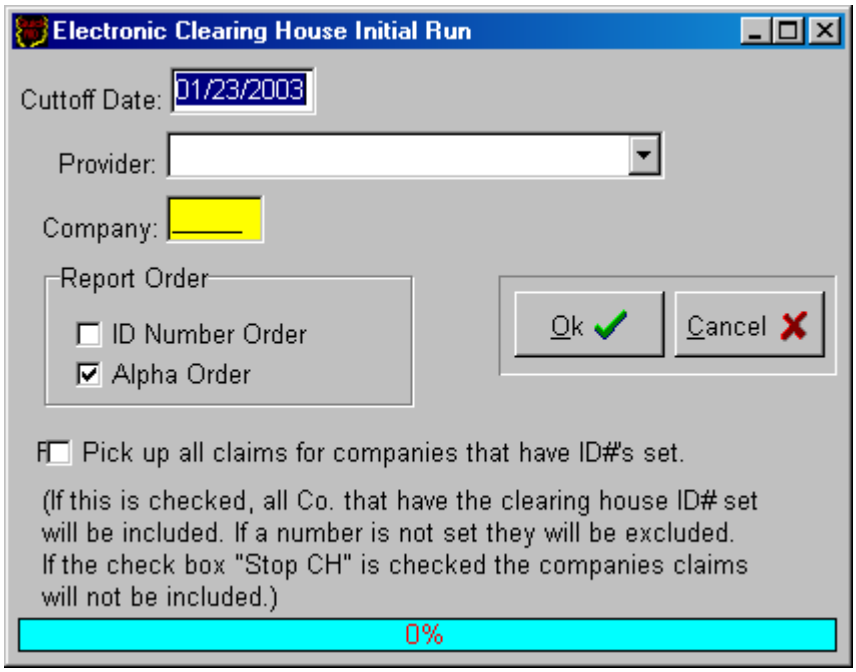
Step 7.

> ***Note:*** *Your claims may not be immediately available for download; processing times are dependent on the insurance company.*

Select **Download Insurance Reports**
At this point a blank screen will be displayed while Quick-MD calls the insurance company.
Once a connection is made the computer will fill out the required information and download the reports.
After the files have finished downloading, exit out of the window.

Electronic Clearing House Billing

Use this feature to file to the other major payers through the Proxy Med clearing house. The steps are the same as above. But the initial run is slightly different.


Electronic Clearing House Initial Run
Cuttoff Date:
01/23/2003
Provider:
Company:
Report Order
ID Number Order
Alpha Order
Ok
Cancel
Pick up all claims for companies that have ID#'s set.
(If this is checked, all Co. that have the clearing house ID# set will be included. If a number is not set they will be excluded. If the check box "Stop CH" is checked the companies claims will not be included.)
0%

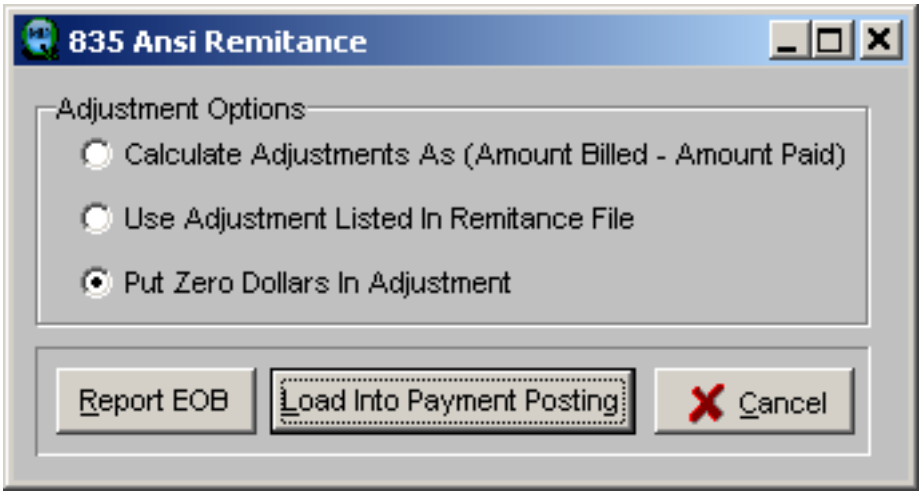
In setting up to send claims to ProxyMed, you will need to insert ProxyMed's Insurance Payer ID#'s in all of the insurance records in Quick-MD that you want to go electronically. They will go in the Clearing House payer ID# field in the master insurance records in Quick-MD. When you run your initial run, you will check the box **Pick up all claims for companies that have ID#'s set.** When you do the Initial Run, Quick-MD will then look through all of the patients that have an insurance company attached to them with the payer ID#'s set, for claims that don't have a red billing note on them.
Repeat steps 1 through 5 above.

E-Bill Reports

To read the response report that you received, from the company that you have billed, you will need to go to **Read E-Bill Reports**. This will bring up the ebill folder. From here you simply double click on the file that you want to open and the system will display the correct report. A TA1 report tells you that the file was transferred to the company correctly. A 997 report, will show you if errors occurred in the format of the file. If any errors come back in the 997 report you will need to resend the entire batch, after the errors has been corrected. Once the claims have been accepted by the insurance company they will run their own set of edits. The file that they send back to you will contain the number of claims excepted and rejected. An 835 file is your electronic remittance file, reporting and automatic posting can be preformed on this file.

ELECTRONIC REMITTANCE (ANSI 835)

Quick-MD will automatically load electronic remittance files directly into the line item payment module. This will drastically reduce the amount of time that it takes an office to input payments.



Calculate Adjustments As (Amount Billed – Amount Paid) - If this option is selected then the adjustment will be the difference between the amount billed and the amount paid.

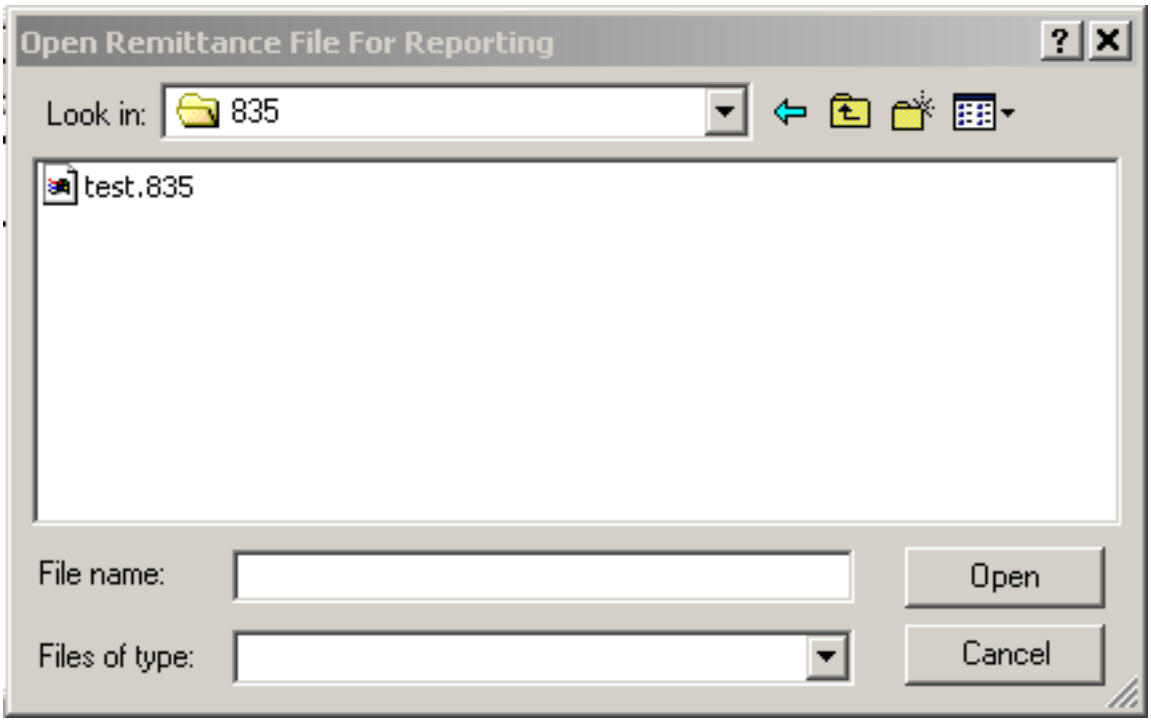
Use Adjustment Listed In Remittance File – If this option is selected then the system will use the adjustment amount returned in the 835 file.

Put Zero Dollars In Adjustment – If this option is selected then the system will use a zero dollar amount for the adjustment.

835 Report

To get a legible report of the 835 file follow the following steps.

1. Click on the **Report EOB** button.
2. The system will now ask you to pick a file. Choose your 835 file and click open.

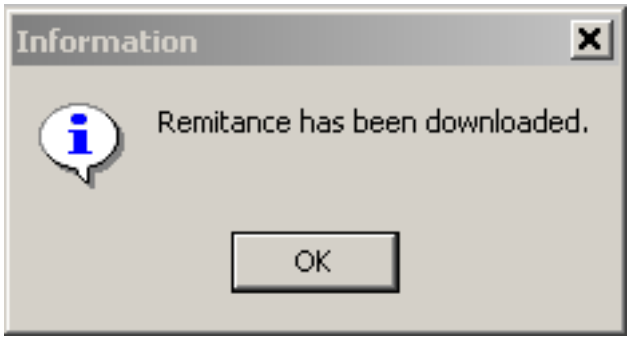


3. Keep a copy of the report for your records.

Loading the 835 file

This option will load the 835 file directly into your payment module.

1. Click on the **Load into Payment Posting** button.
2. Pick your 835 file and click **Open**.
3. Verify that the remittance has been downloaded.



4. Go to the main **payments** menu and choose **Insurance Payments (By Invoice)** or **Insurance Payments (By Claim).**

   Note: *If you have* ***work by line item*** *set in the properties then you will need to choose by invoice, otherwise you will choose by claim.(for more information see page 63)*



5. The payment screen will be populated with all of the information from the remittance file.

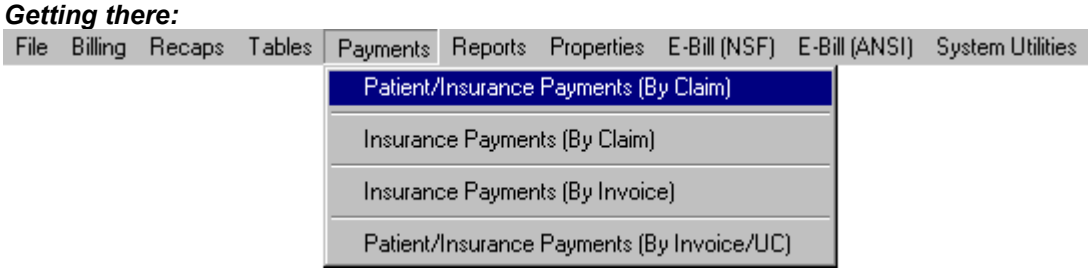
ENTERING PAYMENTS IN QUICK-MD

THE PAYMENTS MENU

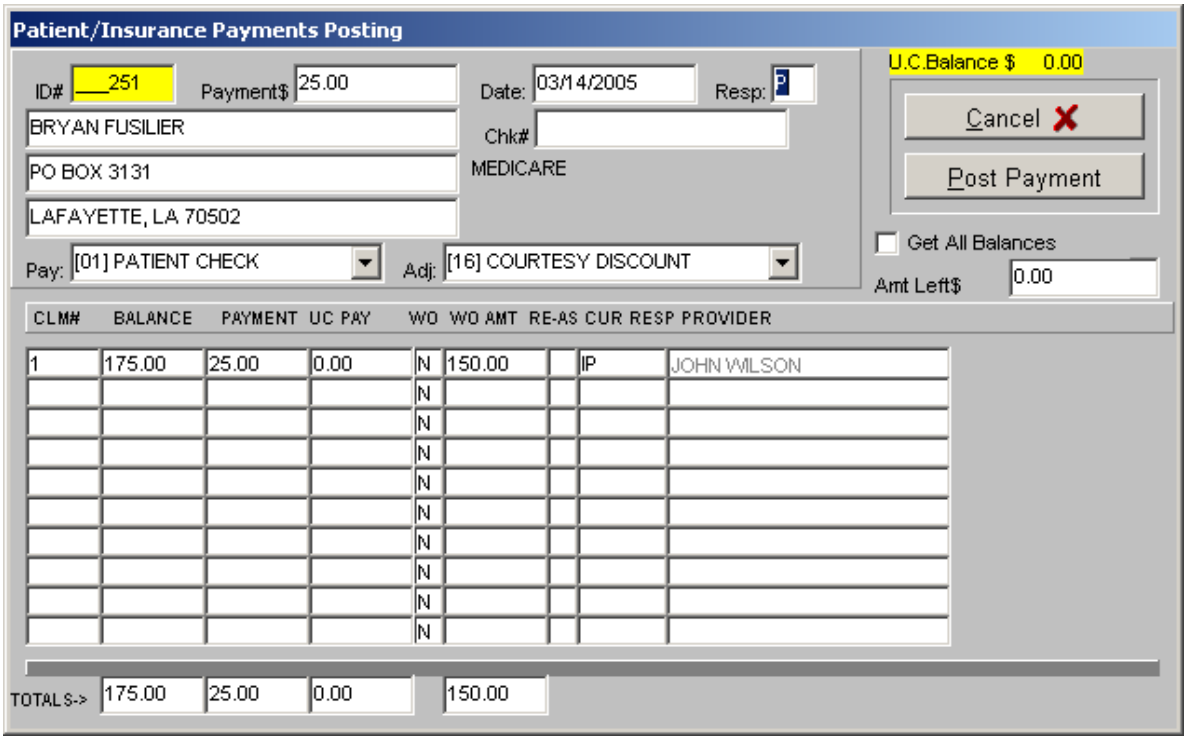
PATIENT/INSURANCE PAYMENTS POSTING

Use the feature to post either Patient or Insurance Payments by Claim.

Getting there:



At Main Menu select "**PAYMENTS**"
At Drop Down Menu select "**PATIENT/INSURANCE PAYMENTS (BY CLAIM)**"



> ***NOTE:*** *This module will pull in Patient responsible claims only, starting with the oldest one in the ledger, if you don't have "**GET ALL BALANCES**" checked. If you want this module to always get all balances, both patient and insurance responsible, check the box **GET ANY BALANCE IN PAYMENT POSTING** in MISCELLANEOUS DEFAULTS (for more information see page 91).*

In the yellow field, enter the patient **ID#.** If you don't know it, the hit the **<F1>** key to browse the patient file and bring in this patient.

Enter the payment amount in the ***PAYMENT*** field.

Enter the **LEDGER DATE** you wish this payment to carry.

Enter the responsibility code that the payment is coming from. **I** for primary insurance, **S** for secondary, **A** for third, or **P** for patient payment.

Enter the check number in the ***CHK#*** field.

Pick your **PAYMENT** and **ADJUSTMENT** codes you wish this entry to carry in the ledger.

Once you have entered the patients ID#, patient responsible claims with a balance will be brought into the module, starting with the oldest first. If you have ***GET ALL BALANCES*** checked, then insurance claims with a balance will also be brought over.

The claim number(s) and the balance of the claim will automatically be displayed. Enter the payment amount in the ***PAYMENT*** field. If the patient has an unapplied credit it will be displayed in the upper right hand corner of the screen. If you wish to apply an unapplied credit, simply type the amount in the ***UC PAYMENT*** field. If you wish to write any portion of the balance off, put a *"Y"* in the ***WRITE OFF*** field and enter the amount in the *WRITE OFF AMOUNT*. The current responsibility is displayed at the far right in the *CURRENT RESP*. field.
If you wish to reassign the balance to a different responsibility, simply enter the code in ***RE-AS FIELD***.

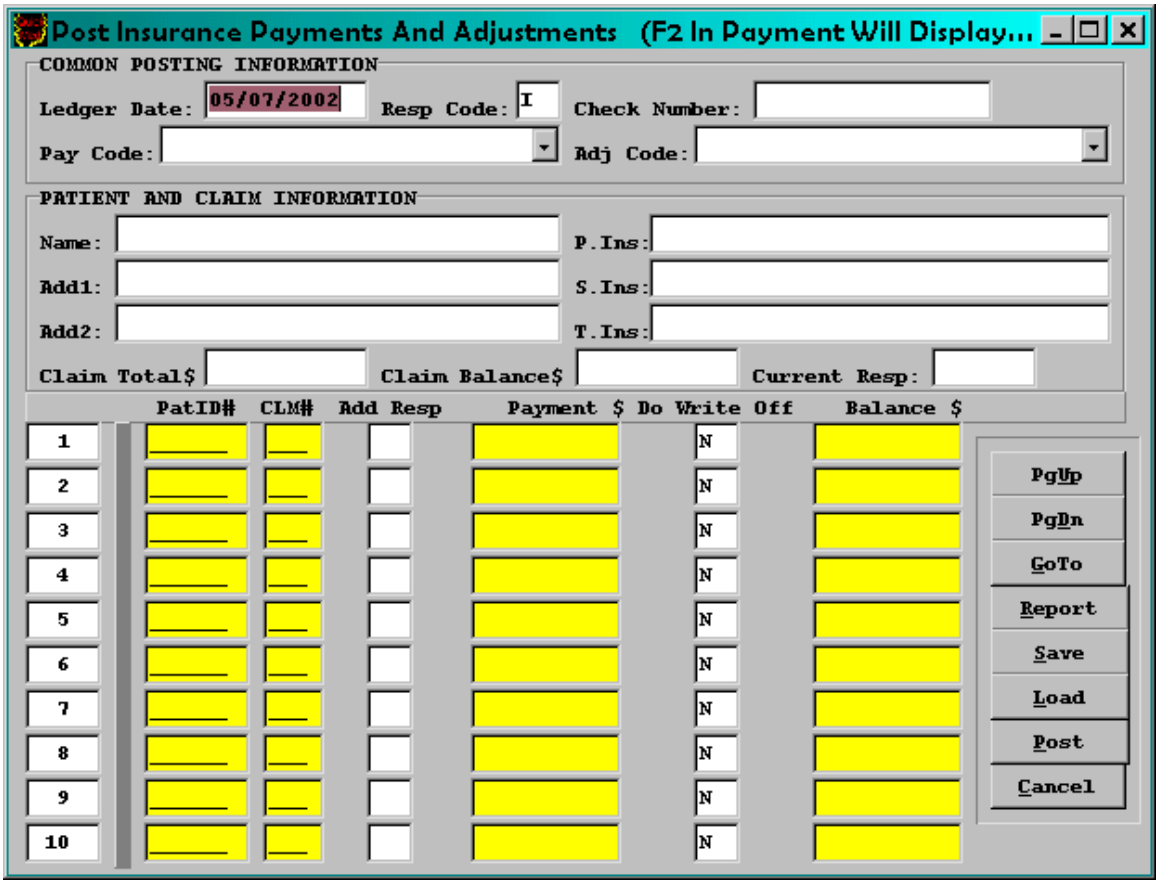
After payment posting is complete select the **<POST PAYMENT>** button, this allows Quick-MD to post the transactions to the Patient's account. If you want to delete a transaction and not post payment, select the **<CANCEL>** button.

After Post Payment is complete, select the **<CANCEL>** button to return to Main Menu.

QUICK INSURANCE PAYMENT POSTING MODULE – BY CLAIM

Getting there:





You should be in the Menu "**POST INSURANCE PAYMENTS AND ADJUSTMENTS**"- **This module will post one payment and one adjustment to the claim as a whole.**

In the section "**COMMON POSTING INFORMATION**, at **LEDGER DATE:** enter date of EOB or press the enter button for today's date.

> ***NOTE:*** *System will default to current date.*

RESP. CODE - System will default to (I) for Insurance payments, Press the **<ENTER>** button.

CHECK NUMBER - Input the check number located on EOB.

PAY SOURCE -Select the **DOWN ARROW BUTTON** located at the end of the **PAY CODE** box and select the appropriate pay source. Press the **ENTER** button.

***NOTE:** To use this feature the **PAYMENT TABLE** (for more information see page 67) must be set with a listing of description types for posting payments.*

ADJ CODE - Select the **DOWN ARROW BUTTON** located at the end of the "adj code" box and select the appropriate adjustment code. Press the **<ENTER>** button.

***NOTE:** To use this feature the **ADJUSTMENT TABLE** (for more information see page 68) must be set with a listing of description enters for posting adjustments.*

System will automatically drop to "**PAT ID#**" Input Patient ID number located on EOB. If ID number is not present, press **<F1>**to search by name.

After Patient ID number has been selected press the **ENTER** button to move to "Claim#"

***NOTE:** Under "Patient and Claim Information" Quick-MD will input the Patient name and address along with the pay source: (P. Ins-primary insurance name, S. Ins-secondary insurance name, T. Ins-third party insurance) for verification.*

CLAIM# - Input the claim number that payment is being made or press the **<F1> key** to go the patient's ledger. Here you can review the claim being paid. At this point you may also press the **Shift + <F1>** key to get to a fully functional ledger browse screen. *(for more information see page 31)*

***NOTE:** While browsing the ledger, you may post a note **(<F3> Key)** to the claim or, if there is a MediGap secondary, you may post a billing note (see commands at the bottom of the screen) so Quick-MD will not pick this claim up during secondary batch billing. With the claim being highlighted, hit the enter key to carry this claim over to the Quick Payment Posting Module.*

ADD RESP - Input the responsibility code for the pay source you want the balance to be transferred for billing. Press the **ENTER** button
Responsibility Code: (**I**)- Insurance, (**S**)- Secondary, (**A**)- Third, (**P**)- Patient Responsibility

PAYMENT$ - Input the total payment amount. To view the "Charge List" press **<F2>**

***NOTE:** "Charge List" can only be accessed through the "Payment$" box*

***NOTE:** Pressing **<F1>** in this field will pop up a calculator that can be used to add numbers. When **<OK>** is clicked, the numbers added will be inserted into that payment field.*

DO WRITE OFF - Input **Y** if you are making an adjustment. Input **N** if no adjustments are to be made.

BALANCE$ - If you selected **Y** to "write off" input the amount you want adjusted from claim total than press the enter button. If you selected **N** to "write off" then the remaining balance will be billed to the selected pay source.

***NOTE:** At Balance$ system will default to current ledger balance, or will reflect the amount of the write off.*

***NOTE:** If you do not have time to finish a bulk EOB, skip number 11 through 14. See steps "To Save An Unfinished EOB Posting.*

After all payments are inputted, select the **REPORT** button to balance payment amount from EOB to Payment amount inputted to computer. To confirm at "Report Posting Information?" select the **YES** button

System will display **INS POSTING REPORT** after payments on report and payments on EOB balance,

Select **<CLOSE>** to return to "Payments and Adjustment" screen

Select the **<POST>** button to enable system to post all payment and adjustment transactions to each claim

Select the **<CANCEL>** button to return to Main Menu

To Save an Unfinished EOB Posting

If you do not have enough time to finish inputting payments and adjustments from a bulk EOB then Select the **<Save>** button

To confirm at “Save Listing?” select the **<Yes>** button

System will read “Listing was Saved”

Select **<Ok>**

Select the **<Cancel>** button to return to Main Menu

Resuming an Unfinished EOB Posting

Getting there:
At “Main Menu”: Select **Payments**
At the drop down menu: Select **Insurance Payments**

In the section “Common Posting Information” At Ledger Date: Input the date of the unfinished EOB

Resp Code - Input Key Alphabet of unfinished EOB

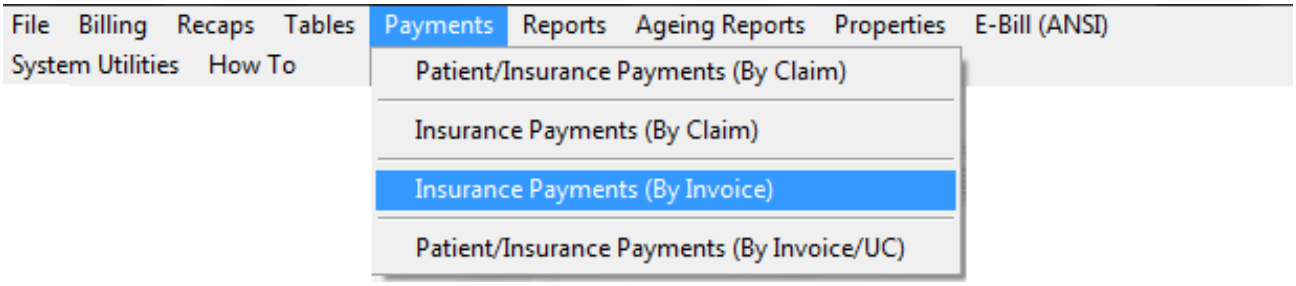
Check Number - Input check number of unfinished EOB. Press the **<enter>** button

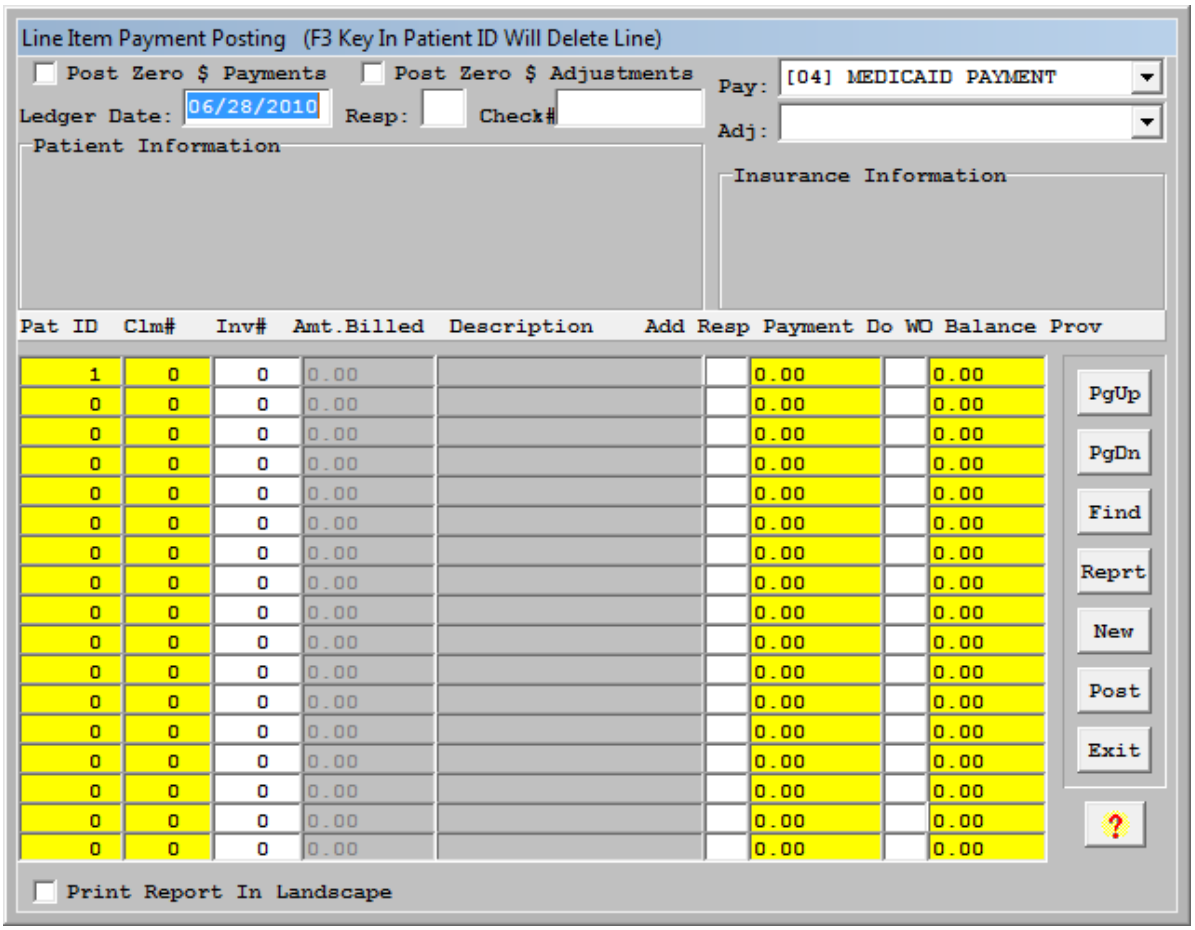
Select the **<Load>** button

To confirm: At “Load Listing?” select **<yes>** to bring all saved payment activity to screen. You can now continue with Posting Payments and Adjustments.

Insurance Payments By Invoice

Getting There:





You will use this payment posting screen the majority of the time since it works with automatic when loading "Line Item" ERAs. If you file Medicare secondary claims electronically then you are required to post your primary payments by line Item. (*(For more information see page 103)*

Post Zero $ Payments – Check this box if you want to post a payment of zero dollars to the patient's ledger. If this box is not checked then zero dollar payments are not posted.

Post Zero $ Adjustments – Check this box if you want to post an adjustment of zero dollars to the patient's ledger. If this box is not checked then zero dollar adjustment are not posted.

Ledger Date – This is the date that all of the payments and adjustments will carry.

RESP. CODE - System will default to (I) for Insurance payments, Press the **<ENTER>** button.

CHECK NUMBER - Input the check number located on EOB.

PAY SOURCE -Select the **DOWN ARROW BUTTON** located at the end of the **PAY CODE** box and select the appropriate pay source. Press the **ENTER** button.

> ***NOTE:*** *To use this feature the **PAYMENT TABLE** (for more information see page 67) must be set with a listing of description types for posting payments.*

ADJ CODE - Select the **DOWN ARROW BUTTON** located at the end of the "adj code" box and select the appropriate adjustment code. Press the <**ENTER>** button.

> ***NOTE:*** *To use this feature the **ADJUSTMENT TABLE** (for more information see page 68) must be set with a listing of description enters for posting adjustments.*

System will automatically drop to "**PAT ID#**" Input Patient ID number located on EOB. If ID number is not present, press **<F1>**to search by name.

After Patient ID number has been selected press the **ENTER** button to move to "Claim#"

> ***NOTE:*** *Under "Patient and Claim Information" Quick-MD will input the Patient name and address along with the pay source: (P. Ins-primary insurance name, S. Ins-secondary insurance name, T. Ins-third party insurance) for verification.*

CLAIM# - Input the claim number that payment is being made or press the **<F1> key** to go the patient's ledger. Here you can review the claim being paid. At this point you may also press the **Shift + <F1>** key to get to a fully functional ledger browse screen. *(for more information see page 31)* Once on the **F1** browse screen you can pres the **<F1> key** again to pull all of the invoice for the claims that is highlighted.

> ***NOTE:*** *While browsing the ledger, you may post a note **(<F3> Key)** to the claim or, if there is a MediGap secondary, you may post a billing note (see commands at the bottom of the screen) so Quick-MD will not pick this claim up during secondary batch billing. With the claim being highlighted, hit the enter key to carry this claim over to the Quick Payment Posting Module.*

ADD RESP - Input the responsibility code for the pay source you want the balance to be transferred for billing. Press the **ENTER** button
Responsibility Code: (**I**)- Insurance, (**S**)- Secondary, (**A**)- Third, (**P**)- Patient Responsibility

PAYMENT$ - Input the total payment amount. To view the "Charge List" press **<F2>**

> ***NOTE:*** *"Charge List" can only be accessed through the "Payment$" box*
>
> ***NOTE:*** *Pressing **<F1>** in this field will pop up a calculator that can be used to add numbers. When **<OK>** is clicked, the numbers added will be inserted into that payment field.*
>
> ***NOTE:*** *You can configure the system to automatically apply insurance recoup adjustments. By entering a negative payment in this field Quick-MD will automatically post the defined adjustment to the ledger. (For more information see page 68)*

DO WRITE OFF - Input **Y** if you are making an adjustment. Input **N** if no adjustments are to be made.

BALANCE$ - If you selected **Y** to "write off" input the amount you want adjusted from claim total than press the enter button. If you selected **N** to "write off" then the remaining balance will be billed to the selected pay source.

> ***NOTE:*** *At Balance$ system will default to current ledger balance, or will reflect the amount of the write off.*

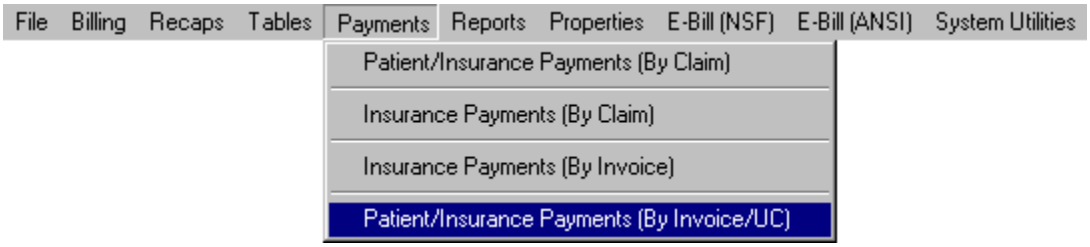
***NOTE:** If you do not have time to finish a bulk EOB, skip number 11 through 14. See steps "To Save An Unfinished EOB Posting.*

After Posting the payments you will want to click on the New button before exiting the screen. This will clear the information. That way the next time you need to post a payment the screen **WILL BE BLANK.**

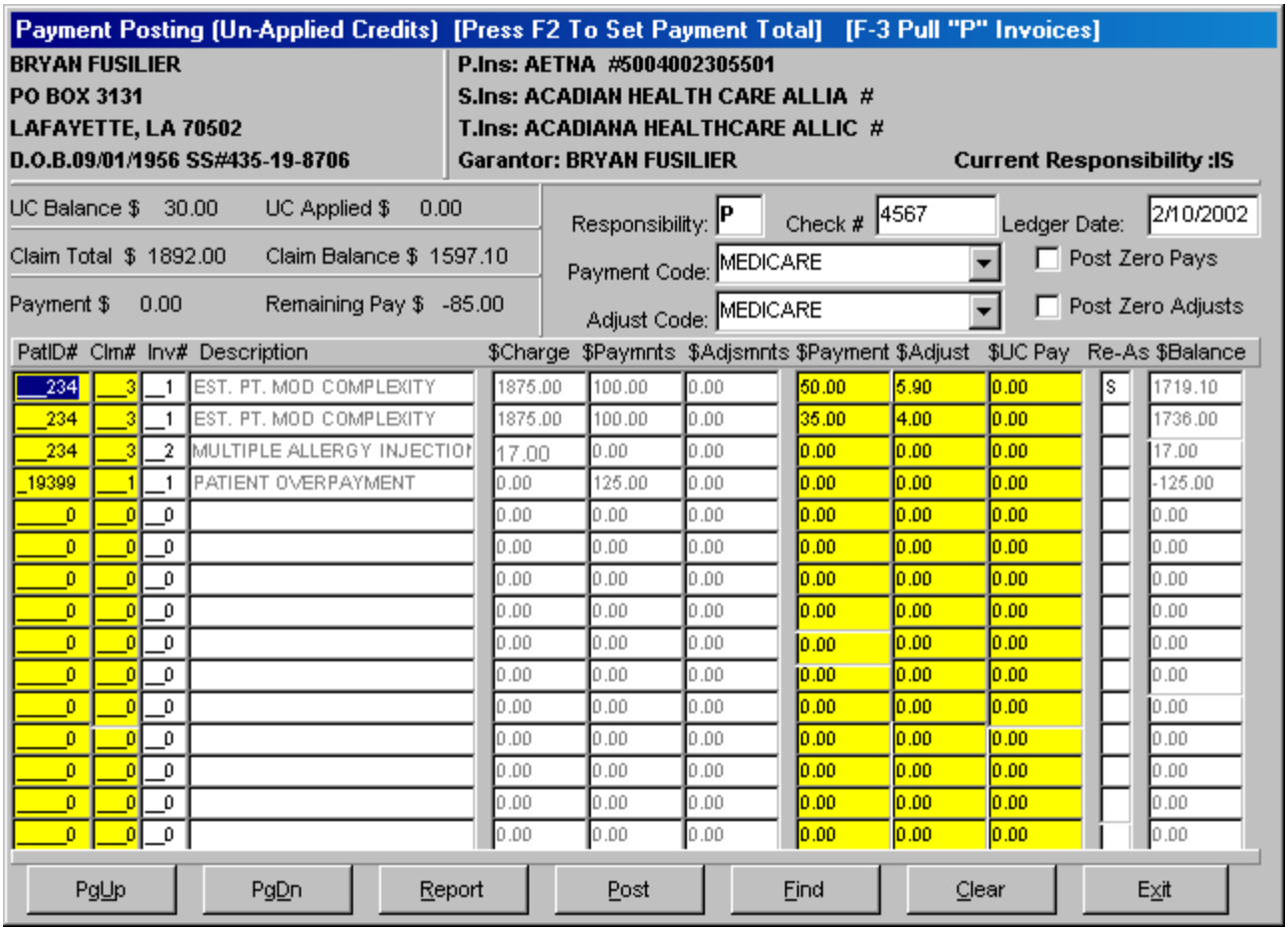
If you did not finishing entering the payment you can Exit the screen. Quick-MD will automatically save your current work and it will be available the next time you open this module.

PATIENT/INSURANCE PAYMENTS (BY INVOICE/UC) – (UNAPPLIED CREDITS)

Getting There:



The screen will open up blank, with the cursor in the responsibility field. Enter the responsibility code that the payment is from (**I**,**S**,**A**, or **P**). Enter the check number of the check in the check # field. Enter the ledger date you wish the entries to carry. Pick a payment and an adjustment code. If you wish to post zero dollar payments and adjustments click in the check boxes.

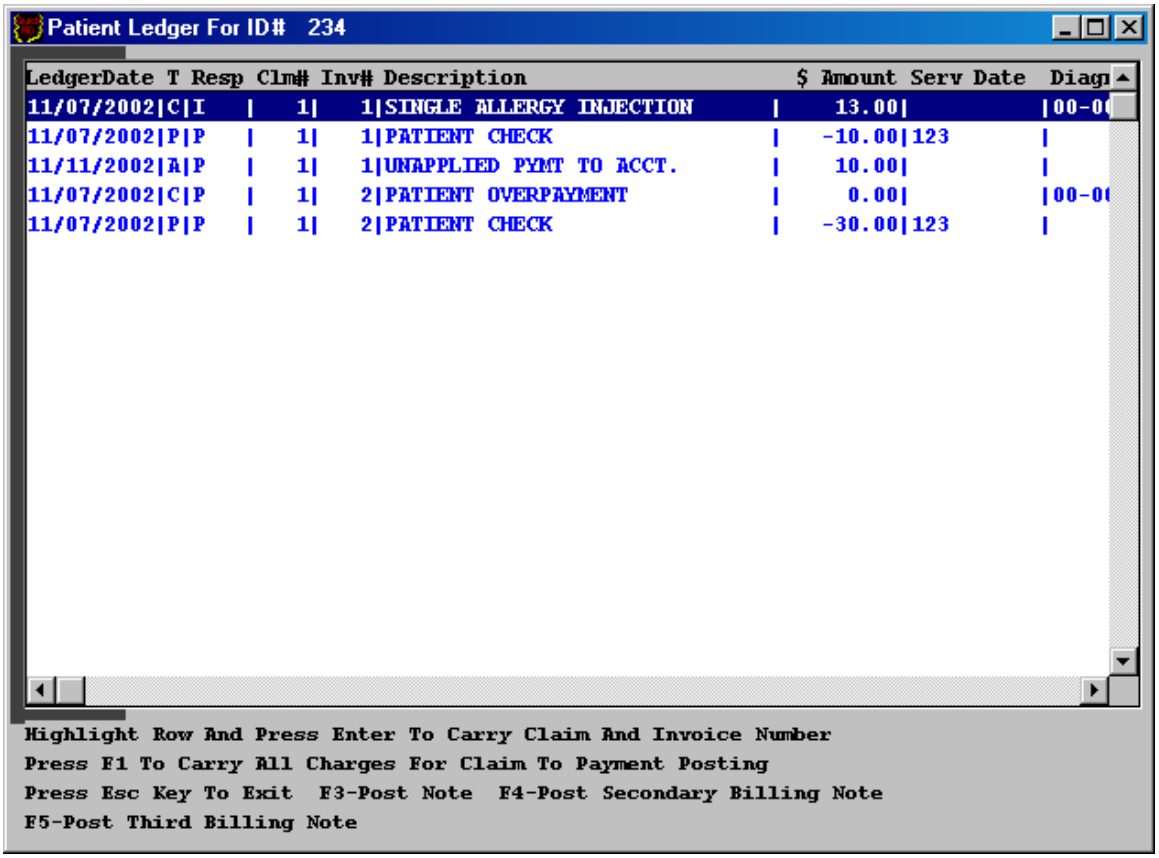

Payment Posting (Un-Applied Credits) [Press F2 To Set Payment Total] [F-3 Pull "P" Invoices]
BRYAN FUSILIER
PO BOX 3131
LAFAYETTE, LA 70502
D.O.B.09/01/1956 SS#435-19-8706
P.Ins: AETNA #5004002305501
S.Ins: ACADIAN HEALTH CARE ALLIA #
T.Ins: ACADIANA HEALTHCARE ALLIC #
Garantor: BRYAN FUSILIER
Current Responsibility :IS
UC Balance $ 30.00
UC Applied $ 0.00
Claim Total $ 1892.00
Claim Balance $ 1597.10
Payment $ 0.00
Remaining Pay $ -85.00
Responsibility: P
Check # 4567
Ledger Date: 2/10/2002
Payment Code: MEDICARE
Post Zero Pays
Adjust Code: MEDICARE
Post Zero Adjusts
PatID# Clm# Inv# Description $Charge $Paymnts $Adjsmnts $Payment $Adjust $UC Pay Re-As $Balance
234 3 1 EST. PT. MOD COMPLEXITY 1875.00 100.00 0.00 50.00 5.90 0.00 S 1719.10
234 3 1 EST. PT. MOD COMPLEXITY 1875.00 100.00 0.00 35.00 4.00 0.00 1736.00
234 3 2 MULTIPLE ALLERGY INJECTION 17.00 0.00 0.00 0.00 0.00 0.00 17.00
19399 1 1 PATIENT OVERPAYMENT 0.00 125.00 0.00 0.00 0.00 0.00 -125.00
PgUp
PgDn
Report
Post
Find
Clear
Exit

If you want to post $0 dollar payments and/or adjustments, click the appropriate box (s).

PAT ID# - enter the patient id#. If you don't know it, you may hit the **<F1>** and browse the patient file. Highlight the desired name, and hit **<ENTER>**.

At this point, if you are only looking for **P** (patient responsible claims) you hit the **<F3>** key and Quick-MD will bring over only patient responsible balances into the module, starting with oldest claims first.

If you are posting insurance payments, at the claim number field, enter the claim number you wish to post a payment to, then hit the **<F1>** key to go straight to that claim in the ledger. If you don't know the claim number, you may hit the **<F1>** key to go browse the ledger.


Patient Ledger For ID# 234
LedgerDate T Resp Clm# Inv# Description $ Amount Serv Date Diagn
11/07/2002|C|I | 1| 1|SINGLE ALLERGY INJECTION | 13.00| |00-0
11/07/2002|P|P | 1| 1|PATIENT CHECK | -10.00|123 |
11/11/2002|A|P | 1| 1|UNAPPLIED PYMT TO ACCT. | 10.00| |
11/07/2002|C|P | 1| 2|PATIENT OVERPAYMENT | 0.00| |00-0
11/07/2002|P|P | 1| 2|PATIENT CHECK | -30.00|123 |
Highlight Row And Press Enter To Carry Claim And Invoice Number
Press F1 To Carry All Charges For Claim To Payment Posting
Press Esc Key To Exit F3-Post Note F4-Post Secondary Billing Note
F5-Post Third Billing Note

Once in the ledger, you highlight an invoice, and hit enter to bring over that invoice, or you may hit the **<F1>** key to bring over all invoices within that claim.

> ***NOTE**: If you are browsing the ledger by date of service and you enter charges the day of the date of service, then the ledger date is your date of service. If your date of service is different than the ledger date (the day you enter the charges - i.e. hospital charges), then go to Properties/Misc. Defaults/Put Service date on ledger Screen and turn this feature on, so the dates of service will be in the Service Date field.*

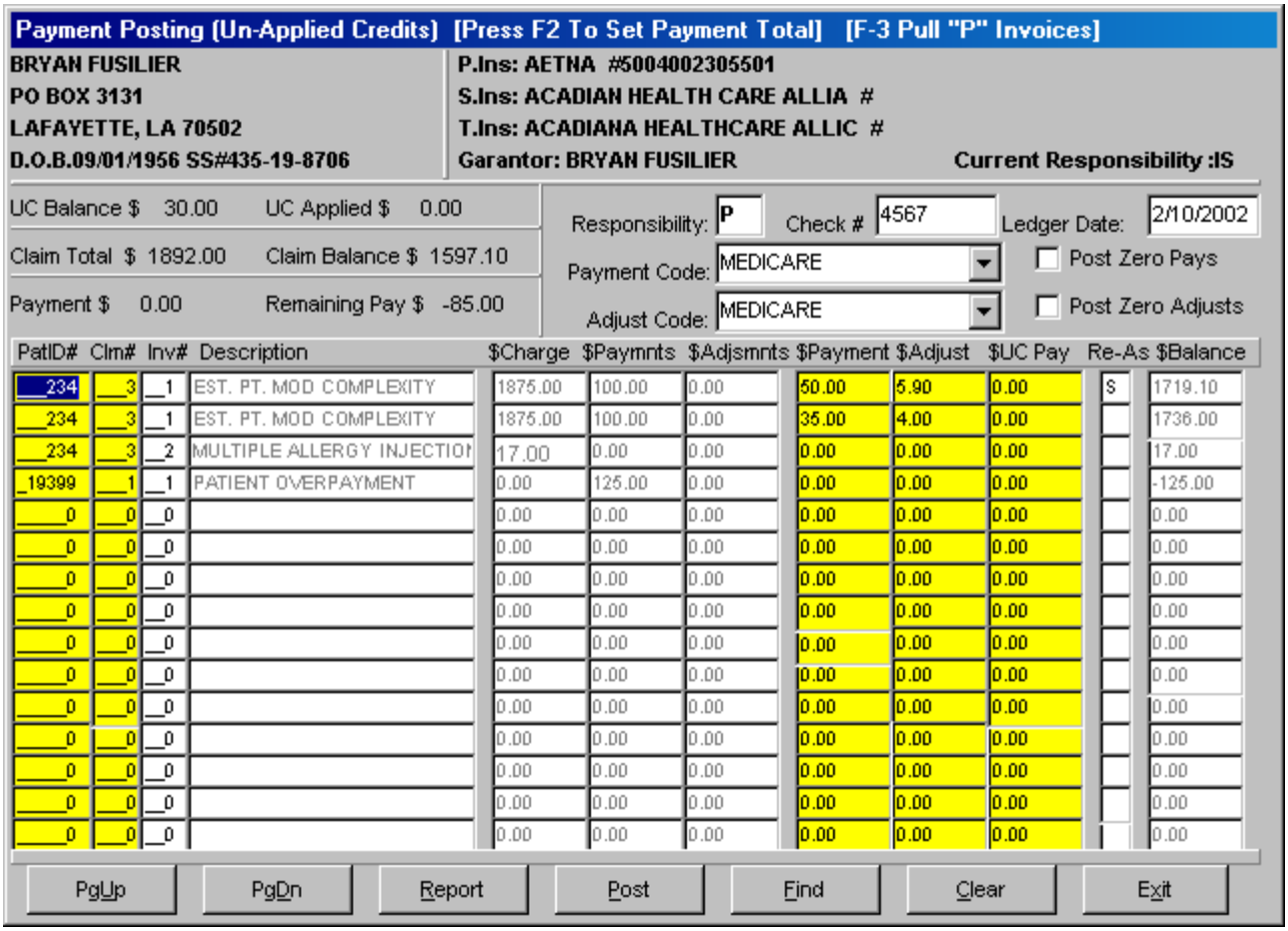
The **<F3>** key will allow you to post a note in the ledger to claim that is highlighted. If you wish this note to print on the patient statement, simply precede the note with an * (asterisk).

> ***IMPORTANT**: If the secondary insurance is an automatic crossover from the primary, you may post a red billing not to the claim so Quick-MD will not pick this claim up and bill it, therefore allowing you to re-assign responsibility to the secondary for reporting purposes.*

Once you have selected the claim and invoices to be paid within that claim, Quick-MD will bring over the existing charge, payments, and adjustments.

The cursor is now in the yellow payment field. (For convenience purposes, from the next three yellow fields, the **<F1>** key will pop up a calculator.) Enter the payment and adjustment. The system is displaying the unapplied credit balances that this patient has right below his name in the UC Balance field. If you wish to apply any of these credits to this balance, simply insert the amount in the UC Pay field.

At this point, if there is a balance, and you wish to reassign that balance to the second or third insurance simply type in the responsibility code (either **S** or **A**) you wish to reassign the balance of the to.


Payment Posting (Un-Applied Credits) [Press F2 To Set Payment Total] [F-3 Pull "P" Invoices]
BRYAN FUSILIER
PO BOX 3131
LAFAYETTE, LA 70502
D.O.B.09/01/1956 SS#435-19-8706
P.Ins: AETNA #5004002305501
S.Ins: ACADIAN HEALTH CARE ALLIA #
T.Ins: ACADIANA HEALTHCARE ALLIC #
Garantor: BRYAN FUSILIER
Current Responsibility :IS
UC Balance $ 30.00
UC Applied $ 0.00
Claim Total $ 1892.00
Claim Balance $ 1597.10
Payment $ 0.00
Remaining Pay $ -85.00
Responsibility: P
Check # 4567
Ledger Date: 2/10/2002
Payment Code: MEDICARE
Post Zero Pays
Adjust Code: MEDICARE
Post Zero Adjusts
PatID# Clm# Inv# Description $Charge $Paymnts $Adjsmnts $Payment $Adjust $UC Pay Re-As $Balance
234 3 1 EST. PT. MOD COMPLEXITY 1875.00 100.00 0.00 50.00 5.90 0.00 S 1719.10
234 3 1 EST. PT. MOD COMPLEXITY 1875.00 100.00 0.00 35.00 4.00 0.00 1736.00
234 3 2 MULTIPLE ALLERGY INJECTION 17.00 0.00 0.00 0.00 0.00 0.00 17.00
19399 1 1 PATIENT OVERPAYMENT 0.00 125.00 0.00 0.00 0.00 0.00 -125.00
PgUp
PgDn
Report
Post
Find
Clear
Exit

When you have finished posting the EOB, you may **<Report>** on your entries to be sure the totals match your check. If there is a discrepancy, you may print out the audit trail in order to find your mistake. When you are satisfied that all is correct, simply hit the **Post** button and Quick-MD will post all of the entries into the patients ledgers.

> ***Note:** If you have lots of entries in the module and need to go back to one in particular, click on the **<Find>** button, enter **Patient ID#** and **Claim #,** and Quick-MD will take you there.*
>
> ***Important:** Do not hit the Post button twice or Quick-MD will post these entries again!*

When you hit the **<Exit>** button Quick-MD will ask you if want to save these entries.

This feature allows you to leave the module, and have the module open back up to where you left off, A great feature for going to lunch or finishing up tomorrow.

When starting a new EOB, simply click on the **<Clear>** button.

RECAPING TRANSACTIONS FOR A DAY IN QUICK-MD

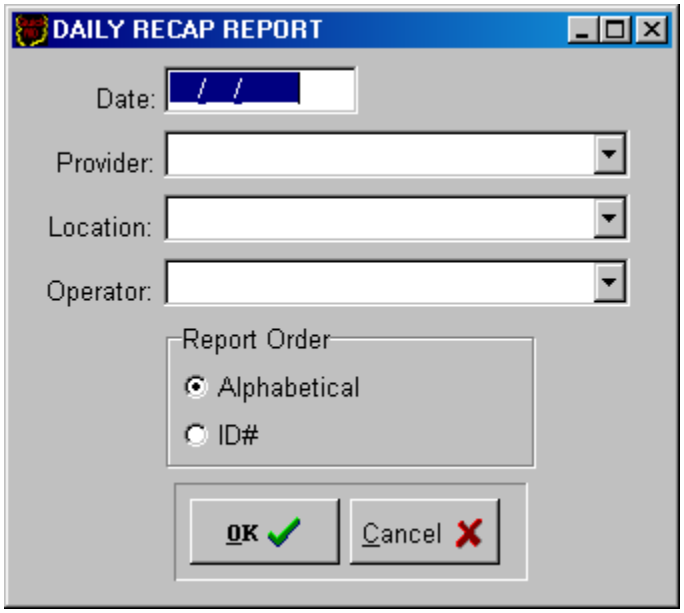
THE RECAPS MENU

Use this feature to recap all activity (charges, payments and adjustments) for a particular date.

> ***NOTE:*** *In order for the operator defined parameter to work, users must make sure that they are logged into a terminal with their own user ID# and password. This can be verified by looking at the operator name on the main screen. (for more information see* ***SET OPERATOR RIGHTS*** *on page 286).*

DAILY RECAP

This feature allows you to print or view an overall itemized daily activity report of transactions entered into Quick-MD. All charges, payments and adjustments will be totaled on this report.
If the totals on this report don't match your hand totals, then a detailed report with a complete audit trail may be run.



DATE – Enter in the date that you want to recap. At a minimum, this field must be filled in.

PROVIDER – This field allows you to choose a provider or leave blank for all.

LOCATION - This field allows you to choose a location or leave blank for all.

OPERATOR - This field allows you to choose an individual operator or leave blank for all.

When done, select **<OK>**.

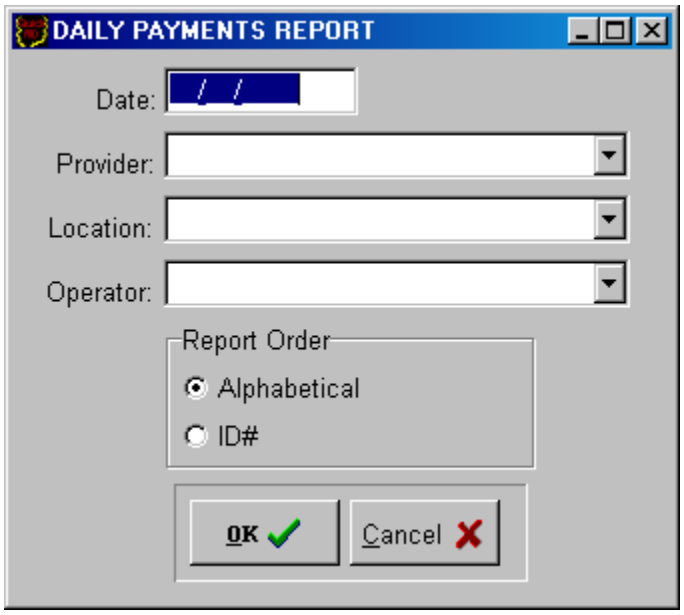
SAMPLE DAILY RECAP REPORT

```
DAILY RECAP:06/25/2003   Page # 1

PATIENT                 PAT.CHRGS INS.CHRGS   PAYMENTS   CRD.AJST   DEB.AJST
================================================================================
    11 FUSILIER, BRENT     0.00      85.00     -20.00       0.00       0.00
     9 FUSILIER, BRYAN     0.00     125.00     -70.00      -8.42       0.00
================================================================================
TOTAL PATIENTS:       2     0.00     210.00     -90.00      -8.42       0.00
TOTAL CHARGES: $210.00
```

Daily Payments

This feature allows you to print or view an overall itemized daily activity report of payments entered into Quick-MD. This report contains the following fields **Patient**, **Patient Charges**, **Insurance Charges**, **Payment**, **Credit Adjustments** and **Debit Adjustments**.



Date – Enter in the date that you want to recap. At a minimum, this field must be filled in.

Provider – This field allows you to choose a provider or leave blank for all.

Location - This field allows you to choose a location or leave blank for all.

Operator - This field allows you to choose an individual operator or leave blank for all.

When done **<Ok>**.

Sample Daily Payments Report

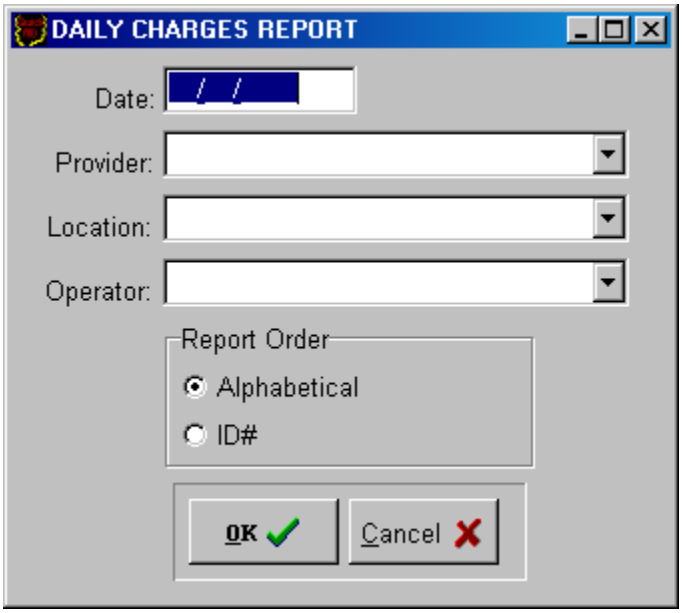
```
DAILY PAYMENT RECAP FOR 06/25/2003                                    Page # 1

PAYMENT              PATIENT                    CLM# INV# CHECK#        AMOUNT
================================================================================
PATIENT CHECK            11 FUSILIER, BRENT       3    1 132             20.00
PATIENT CHECK             9 FUSILIER, BRYAN       2    1 432             40.00
PATIENT CHECK             9 FUSILIER, BRYAN       1    1                 30.00
------------                                                          ----------
TOTAL:    3                                                             90.00

================================================================================
GRAND TOTAL:                                                      $     90.00
```

Daily Charges

This feature allows you to print or view an overall itemized daily activity report of charges entered into Quick-MD. The report generated contains the following fields **Payment**, **Patient**, **Claim #**, **Invoice #**, **Check #** and **Amount**.



Date – Enter in the date that you want to recap. At a minimum, this field must be filled in.

Provider – This field allows you to choose a provider or leave blank for all.

Location - This field allows you to choose a location or leave blank for all.

Operator - This field allows you to choose an individual operator or leave blank for all.

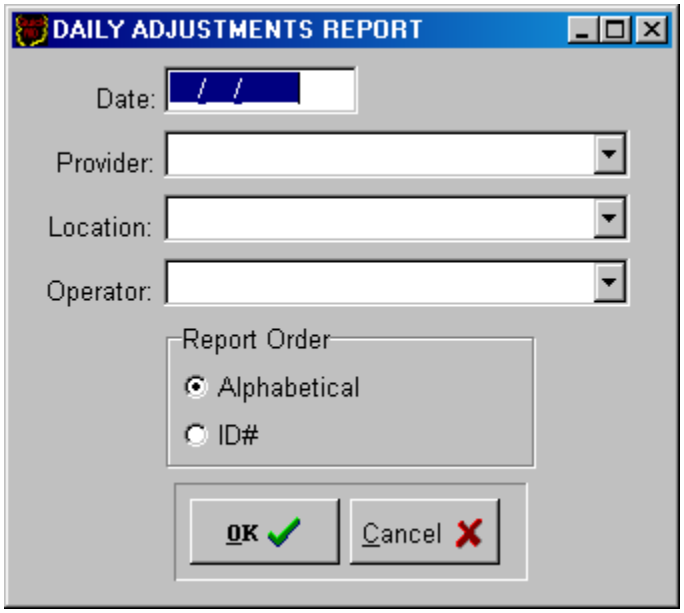
When done **<Ok>**.

Sample Daily Charges Report

```
DAILY CHARGES RECAP FOR 10/27/2004    Page # 1
   ID# Patient Name              CPT Code          CPT Description                $
Amount  Units
================================================================================================
===========
     8 ALDER, JACOB              99212-RH          OFFICE VISIT
40.00   1.00
     9 FUSILIERJR, BRYAN         99212-LH          OFFICE VISIT
40.00   1.00
------------------------------------------------------------------------------------------------
-----------
TOTAL NUMBER OF CHARGES ---->    2
```

DAILY ADJUSTMENTS

Use this feature to print or view an overall itemized daily activity report of adjustments entered into Quick-MD. The report generated contains the following fields **ADJUSTMENT**, **PATIENT**, **CLAIM #, INVOICE #, CHECK #** and **AMOUNT**.



DATE – Enter in the date that you want to recap. At a minimum, this field must be filled in.

PROVIDER – This field allows you to choose a provider or leave blank for all.

LOCATION - This field allows you to choose a location or leave blank for all.

OPERATOR - This field allows you to choose an individual operator or leave blank for all.

When done **<OK>**.

SAMPLE DAILY ADJUSTMENTS REPORT

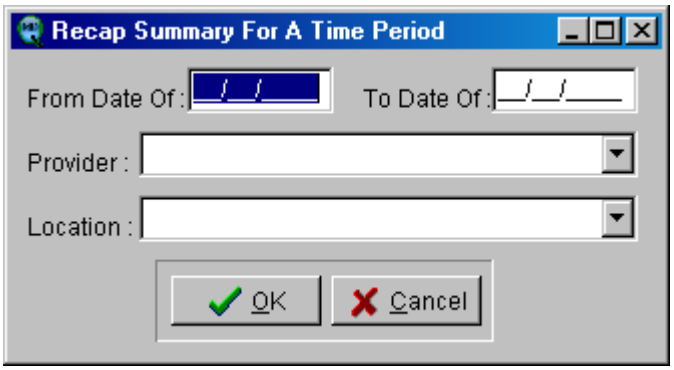
```
DAILY ADJUSTMENT RECAP FOR 06/25/2003                                  Page # 1

ADJUSTMENT           PATIENT               CLM# INV# CHECK#        AMOUNT
================================================================================
PATIENT WRITEOFF    9 FUSILIER, BRYAN       1    1                  -3.42
PATIENT WRITEOFF    9 FUSILIER, BRYAN       1    1                  -5.00

                                                                   ------------
TOTAL:    2                                                           -8.42

================================================================================
GRAND TOTAL:                                                  $        -8.42
```

Recap Summary For a Time Period



Use this feature to recap daily summaries for a specified date range.

Sample Recap Summary for Time Period Report

```
Recap Summary From 01/01/2000 To 06/25/2003 Page # 1

Date        Pat Chrgs  Ins Chrgs  Tot Chrgs   Payments Credit Adj  Debit Adj
================================================================================
12/01/2000     700.00     562.50    1262.50    -145.00       0.00       0.00
12/05/2000       0.00       0.00       0.00       0.00     -20.00       0.00
12/14/2000       0.00       0.00       0.00    -335.00    -142.50       0.00
12/28/2000       0.00       0.00       0.00     -20.00       0.00       0.00
01/17/2003     100.00       0.00     100.00     -40.00       0.00       0.00
01/24/2003     200.00       0.00     200.00       0.00       0.00       0.00
02/02/2003       0.00     583.00     583.00     -70.00       0.00       0.00
06/25/2003       0.00     210.00     210.00     -90.00      -8.42       0.00
--------------------------------------------------------------------------------
            1000.00    1355.50    2355.50    -700.00    -170.92       0.00
```

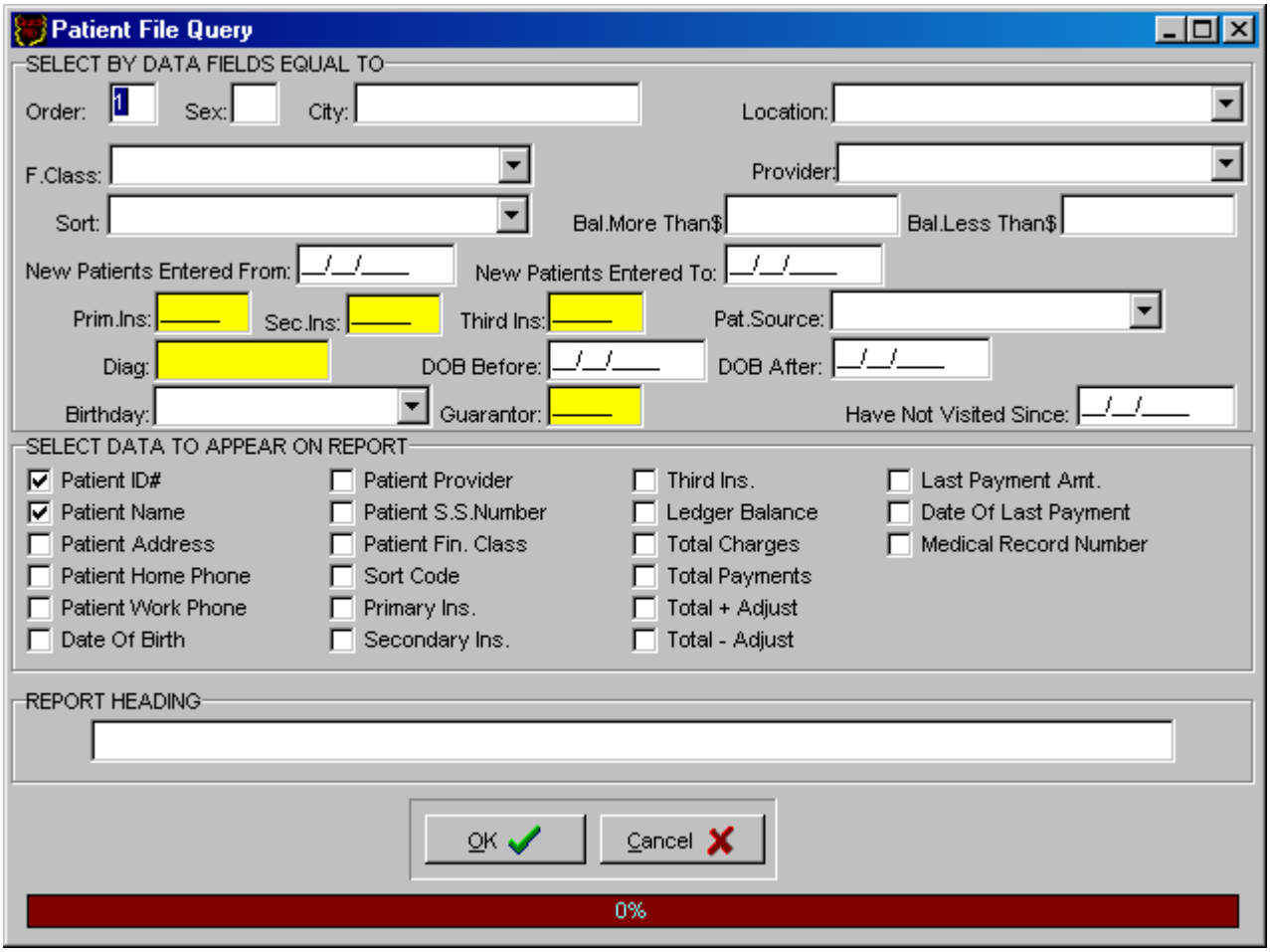
ANALYZING YOUR INFORMATION IN QUICK-MD

THE REPORTS MENU

The reports menu is your window into your data. Here you can find meaningful answers to the questions presented to you in the course of running your practice.

Query Patient File

Use the powerful Query to see any data in any format you choose about your patients. There are actually hundreds, if not thousands, of possible reports that can be generated in seconds!



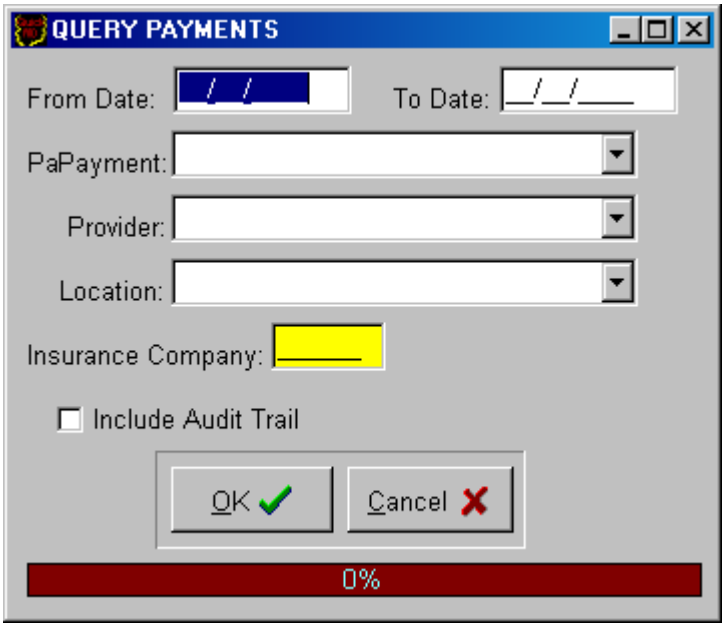
Use this feature to select the criteria that you wish to report on. You may select the order of the report:

- 1 = sort by ID#
- 2 = Sort Alphabetically
- 3 = Sort by zip code

Simply define to Quick-MD what information you would like reporting on and then click in the boxes of the information you want to appear on the report, give the report a name, and then click on **<Ok>**. The report will come to the screen, giving the user the option of printing the whole report by selecting the *Print All* button, or paging down to the end, the user can print only the totals by using the *Print Screen* button.

Query Payments

Use this feature to generate a report history on payment description enters that are set in the **Payment Table** *(for more information see page 67)*. The report generated contains the following fields: **Type of Payment**, **Count** and **Total**.



If any of the fields are left blank, then the report is for all of the payments, all providers and all locations and insurance companies. But if so desired, then the report can be narrowed down to whatever parameters the user selects.

By selecting **Include Audit Trail**, Quick-MD will generate a detailed report. The report generated will now contain the following fields: **Id**, **Patient Name**, **Type of Payment**, **Date**, **Claim #** and **Amount**.

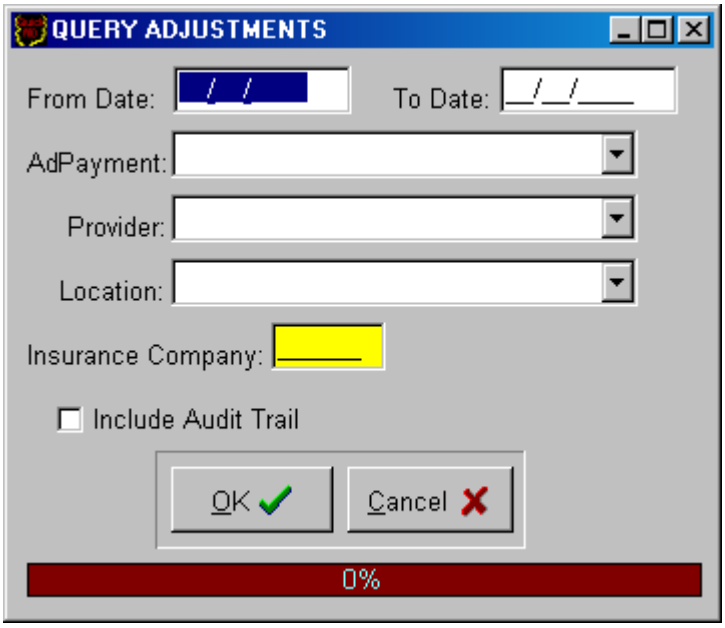
SAMPLE QUERY PAYMENTS REPORT:

PAYMENTS FROM:01/01/2000 TO:06/24/2003 Page # 1

ID#	PATIENT NAME	TYPE OF PAYMENT	DATE	CLM#	$ AMOUNT
3	MIKE SMITH	PATIENT CHECK	12/01/2000	1	25.00
4	DEBRA TURNER	PATIENT CHECK	12/01/2000	1	80.00
6	SANDRA RYAN	PATIENT CHECK	12/01/2000	1	20.00
7	DAVID RYAN	PATIENT CHECK	12/01/2000	1	20.00
2	JOHN SMITH	MEDICAID PAYMENT	12/14/2000	1	80.00
3	MIKE SMITH	AETNA PAYMENT	12/14/2000	1	75.00
5	SEAN DEVERON	PATIENT CHECK	12/14/2000	1	60.00
6	SANDRA RYAN	AETNA PAYMENT	12/14/2000	1	60.00
7	DAVID RYAN	AETNA PAYMENT	12/14/2000	1	60.00
2	JOHN SMITH	CIGNA PAYMENT	12/28/2000	1	20.00
8	JACOB ALDER	PATIENT CHECK	01/17/2003	2	20.00
8	JACOB ALDER	PATIENT CHECK	01/17/2003	1	20.00
9	BRYAN FUSILIER	MEDICARE PAYMENT	02/12/2003	1	75.00
9	BRYAN FUSILIER	BLUE CROSS PAYMENT	02/12/2003	1	20.00
8	JACOB ALDER	PATIENT CHECK	02/19/2003	1	580.00
8	JACOB ALDER	PATIENT CHECK	02/19/2003	2	420.00
8	JACOB ALDER	PATIENT CHECK	02/19/2003	3	25.00
9	BRYAN FUSILIER	PATIENT CHECK	02/19/2003	8	200.00
9	BRYAN FUSILIER	PATIENT CHECK	02/19/2003	2	80.00
9	BRYAN FUSILIER	PATIENT CHECK	02/19/2003	4	100.00
9	BRYAN FUSILIER	PATIENT CHECK	02/19/2003	5	95.00
9	BRYAN FUSILIER	PATIENT CHECK	02/19/2003	10	400.00
15	KIRK SMITH	PATIENT CHECK	03/11/2003	1	20.00
5	SEAN DEVERON	PATIENT CHECK	03/17/2003	2	20.00
22	BRYAN FUSILIER	PATIENT CHECK	03/28/2003	2	20.00
9	BRYAN FUSILIER	PATIENT CHECK	04/03/2003	11	20.00
9	BRYAN FUSILIER	PATIENT CHECK	04/09/2003	11	45.00
9	BRYAN FUSILIER	MEDICAID PAYMENT	05/13/2003	23	75.00
31	KEITH KRAMER	MEDICAID PAYMENT	05/19/2003	1	80.00
9	BRYAN FUSILIER	PATIENT CHECK	06/17/2003	2	20.00
9	BRYAN FUSILIER	PATIENT CHECK	06/17/2003	14	100.00
9	BRYAN FUSILIER	PATIENT CHECK	06/17/2003	15	30.00
36	TONYA FUSILIER	PATIENT CHECK	06/24/2003	5	200.00

TYPE OF PAYMENT	COUNT	$ TOTAL
PATIENT CHECK	24	2620.00
MEDICAID PAYMENT	3	235.00
MEDICARE PAYMENT	1	75.00
BLUE CROSS PAYMENT	1	20.00
AETNA PAYMENT	3	195.00
CIGNA PAYMENT	1	20.00
	33	3165.00

Query Adjustments



Use this feature to generate a report on adjustments that were used during the time frame specified. At **Adj. Type** make a selection from the **Adjustment Table** *(for more information see page 68)*. The report generated contains the following fields: **Id#**, **Patient Name**, **Type of Adjustment**, **Date**, **Claim #**, **Invoice #**, **Check #** and **Amount**.

Sample Query Adjustments Report:

```
DAILY ADJUSTMENT RECAP FOR 06/25/2003                                  Page # 1

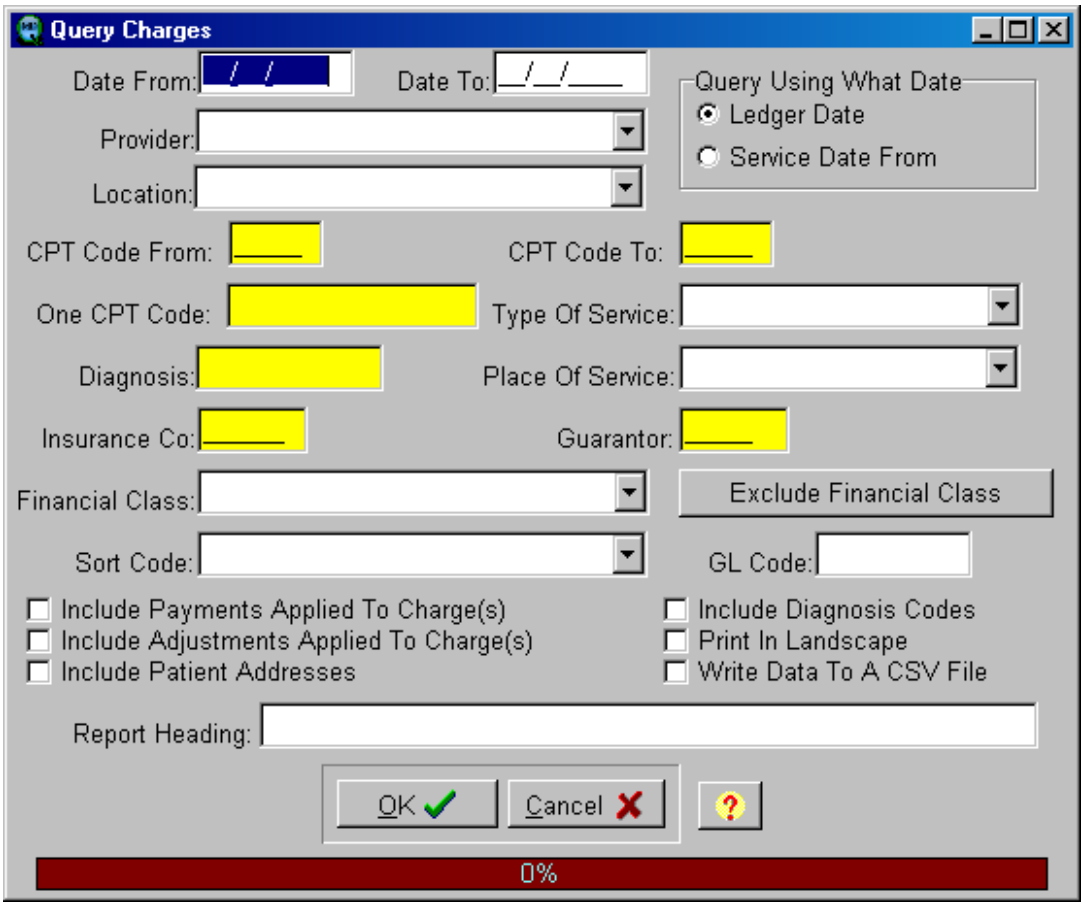
ADJUSTMENT            PATIENT                CLM# INV# CHECK#         AMOUNT
================================================================================
PATIENT WRITEOFF    9 FUSILIER, BRYAN         1    1                   -3.42
PATIENT WRITEOFF    9 FUSILIER, BRYAN         1    1                   -5.00

                                                                     ------------
TOTAL:    2                                                             -8.42

================================================================================
GRAND TOTAL:                              $   -8.42
```

Query Charges

Use this feature to generate a report on Charge codes or Diagnosis codes that are set in the **Cpt Code Table** *(for more information see page 43)* and have been used to generate charges. The report generated contains the following fields: **Id#**, **Patient Name**, **Claim #**, **Invoice#**, **CPT Code**, **Description**, **Units**, **Ledger Date** and **Amount**.



Simply select a date range that you wish to see reporting on, and select the parameters for the report or leave blank to include all. Select the CPT code, you can use a numerical from and to code to get information about a range of CPT codes, or Diagnosis code, and check the information you wish to see on the report, give the report a name and click the **<Ok>** button. You may print all or page down to the end and print screen and print only the totals. You can use a numerical from and to code on the query charge report to get information about a range of CPT codes.

SAMPLE QUERY CHARGES REPORT:

```
ID#    PATIENT NAME  CLM# INV# CPT CODE  DESCRIPTION         UNITS LEDG.DATE    $ AMOUNT
================================================================================
9 BRYAN FUSILIER     3    1 99225        OFFICE VISIT - NEW   1.00 02/12/2003     125.00
Diagnosis:100

8 JACOB ALDER        3    1 99225        OFFICE VISIT - NEW   1.00 02/19/2003     125.00
Diagnosis:789.0
PAY:02/19/2003 JACOB ALDER               PATIENT CHECK                            -25.00

9 BRYAN FUSILIER     7    1 99225        OFFICE VISIT - NEW   1.00 02/19/2003     125.00
Diagnosis:100
ADJ:02/19/2003 BRYAN FUSILIER            TRANSFER IN                             -100.00
ADJ:02/19/2003 BRYAN FUSILIER            TRANSFER IN                              -25.00

 9 BRYAN FUSILIER    5    1 99225        OFFICE VISIT - NEW    1.00 02/19/2003    125.00
Diagnosis:100
PAY:02/19/2003 BRYAN FUSILIER            PATIENT CHECK                            -95.00
ADJ:02/19/2003 BRYAN FUSILIER            TRANSFER IN                              -30.00

8 JACOB ALDER        4    1 99225        OFFICE VISIT - NEW    1.00 03/11/2003    125.00
Diagnosis:789.0

8 JACOB ALDER        5    1 99225        OFFICE VISIT - NEW    1.00 03/11/2003    125.00
Diagnosis:789.0

15 KIRK SMITH        1    1 99225        OFFICE VISIT - NEW    1.00 03/11/2003    125.00
Diagnosis:100

15 KIRK SMITH        1    2 99225        OFFICE VISIT - NEW    1.00 03/11/2003    125.00
Diagnosis:100
PAY:03/11/2003 KIRK SMITH                PATIENT CHECK                            -20.00

9 BRYAN FUSILIER    11    1 99225        OFFICE VISIT - NEW    1.00 03/14/2003    125.00
Diagnosis:100
PAY:04/03/2003 BRYAN FUSILIER            PATIENT CHECK                            -20.00
PAY:04/09/2003 CIGNA                     PATIENT CHECK                            -45.00
ADJ:03/14/2003 BRYAN FUSILIER            TRANSFER IN                              -30.00

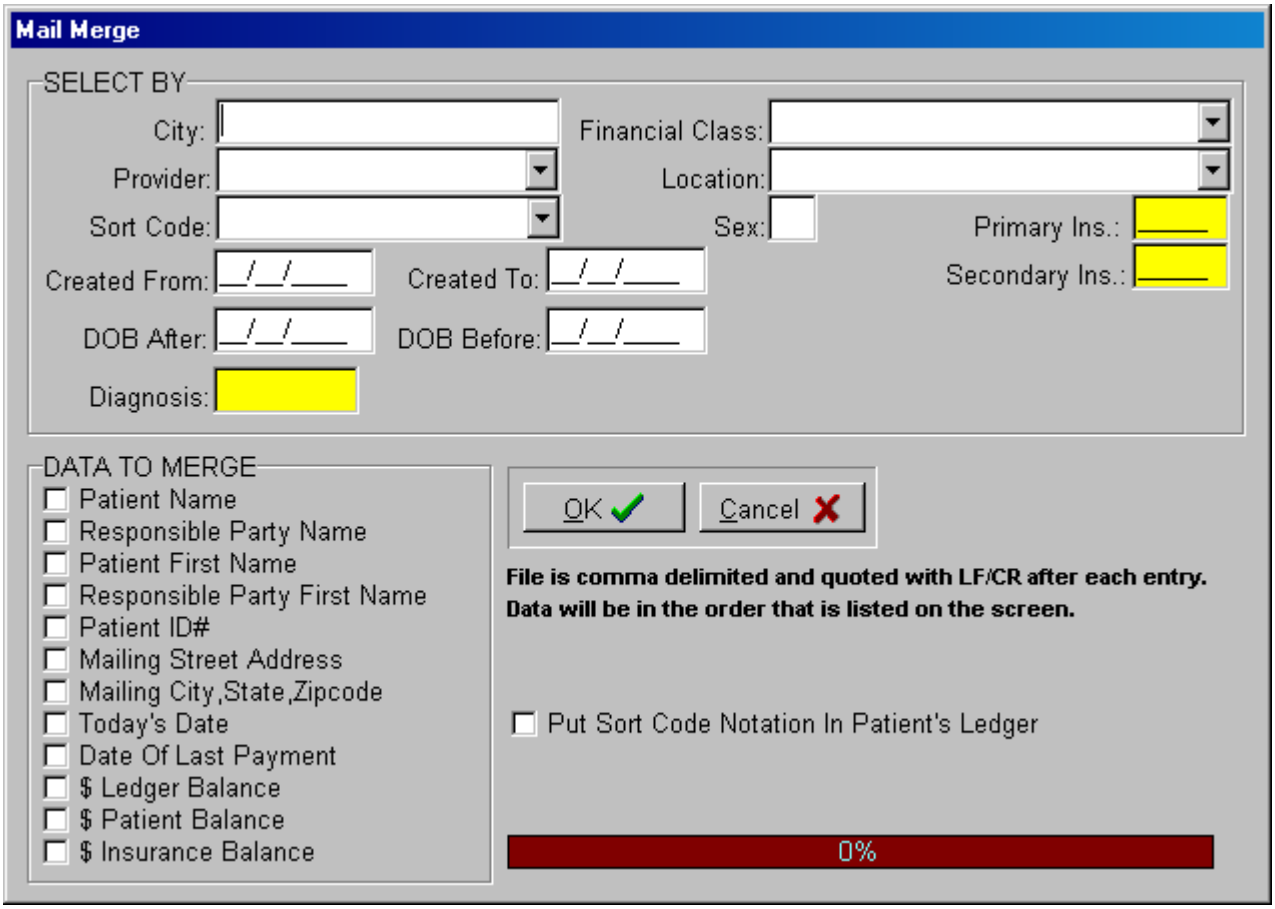


QUERY TOTALS
================================================================================
TOTAL CHARGES.............$   6700.00
TOTAL CHARGE RECORDS......:    33
TOTAL UNITS OF SERVICE....:     37.00
RECEIVABLE................$   3929.60
AVERAGE CHARGE PER UNIT...$    181.08

PATIENT CHECK                    425.00
MEDICAID PAYMENT                 155.00
                              ==========
                                 580.00

PATIENT WRITEOFF               -2000.00
MEDICAID WRITE-OFF                -5.40
COMMERCIAL WRITE OFF            -185.00
                              ==========
                                -2190.40
```

Mail Merge



Use this feature to mail merge information with Word or Word Perfect documents. It is used primarily, however, to generate canned collection letters on delinquent accounts.

> ***Note:*** *Before you can use the Mail Merge function, a path and file name must be set up. This maintenance is performed in* ***Miscellaneous Defaults*** *(for more information see page 91).*

To Generate Collection Letter 1:

When accounts are chosen for collections, one sort code within the Patient file needs to be set to "**Collection Letter 1**". This is accomplished by generating an ageing report, deciding which accounts will go to collections, and then setting the sort code for each of those patients. Once done, the screen above can be completed for the "select by" section (at a minimum, sort code needs to be defined). The "**data to merge**" section is then completed with the information you want to see on the collection letter. Once complete, click **<Ok>** and proceed with the mail merge function within Word or Word Perfect. This will complete the task of sending out collection letter 1.

To Generate Collection Letter 2:

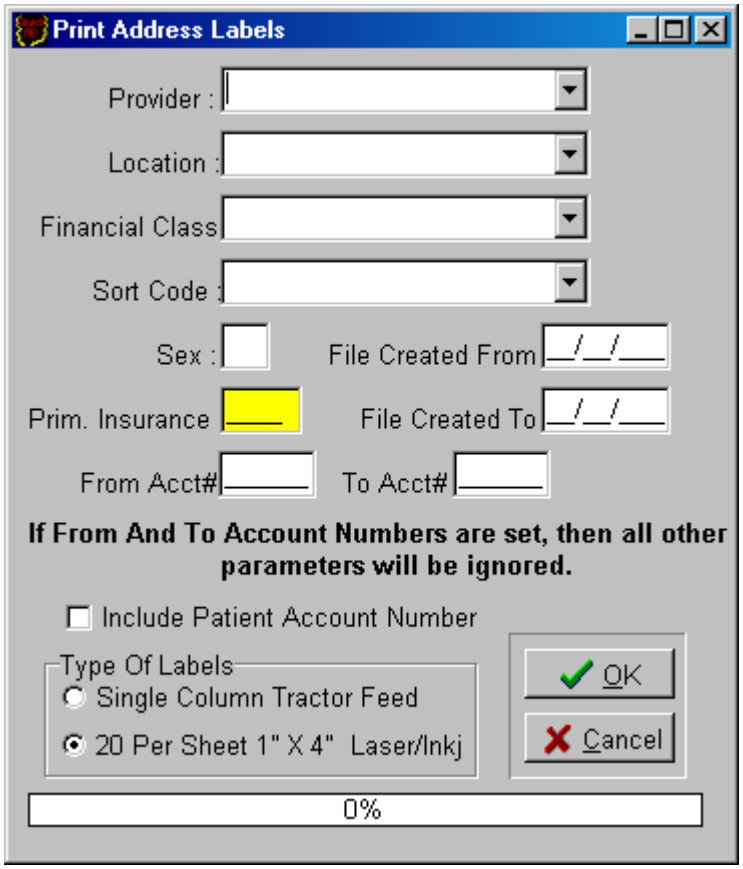
To send out the second of three collection letters on accounts that are still unpaid, you will first need to change the sort code on those accounts. Unlike the initial task of manually setting the sort code to "**Collection Letter 1**", Quick-MD will automatically accomplish this task by using **Reassign Sort Code** *(for more information see page 291)*. Once that task is completed, go through the same procedure above, choosing the sort code of "Collection Letter 2".

To Generate Collection Letter 3:

To send out the third of three collection letters on accounts that are still unpaid, you will first need to change the sort code on those accounts. Quick-MD will automatically accomplish this task by using **Reassign Sort Code** *(for more information see page 291)*. Once that task is completed, go through the same procedure above, choosing the sort code of "**Collection Letter 2**".

Note: *The 3 collection letter process is a common procedure used. However, Quick-MD does not restrict you to using 3. You can do less than three or more than 3. The process above would be repeated for the number of collection letters you are using. When the patient pays, remember to go un-set the sort code so they will not be picked up in the next run.*

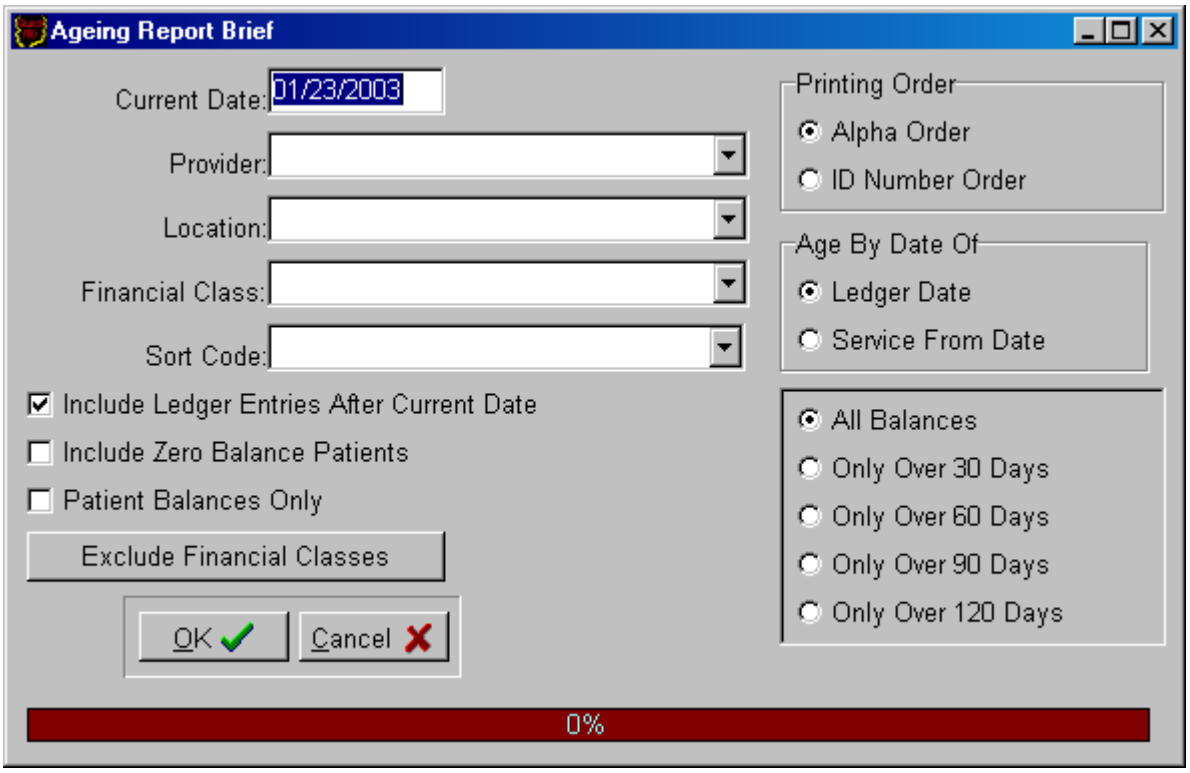
Print Labels



You may print labels out of Quick-MD with either your tractor feed printer using single column labels, or with your laser/inkjet print using 2 column 1 inch by 4 inch labels. The lines to skip between labels for the tractor feed are defined in **Properties/Printed Forms/ Add Laser/Ink settings/lines to skip for labels** as is the set up for the Laser labels.

AGEING REPORT (BRIEF)

Use this feature to generate a brief account's receivable aging report that will include the **PATIENT'S NAME, PHONE NUMBER, DATE OF LAST PAYMENTS**, and any **OUTSTANDING BALANCE** for Patient and/or Insurance balances. You have the ability to exclude any financial class from this report.



***NOTE:** If you check **PATIENT BALANCES ONLY 'AND'** ask for **ALL BALANCES**, you can effectively use this report as a pre-billing run for patient statements.*

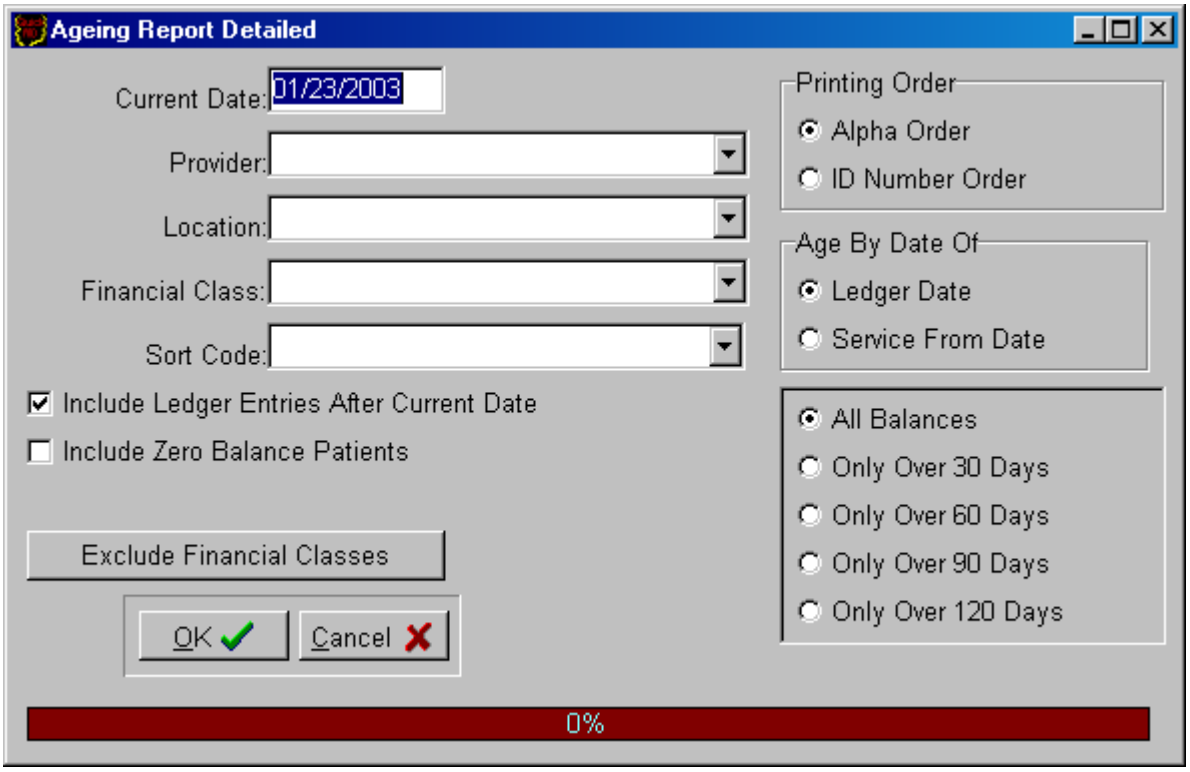
***IMPORTANT:** If the Block Bill feature of the patient demographic screen contains a P, then be aware that these statements will show up in the pre-billing run but will NOT actually be a part of the batch run.*

SAMPLE AGEING REPORT (BRIEF):

** ACCOUNT AGING REPORT AS OF 06/24/2003 ALL PROVIDERS
Page 1

Acct#	Name	Home Phone	DOL Pay	Current	31 - 60	61 - 90	91 -120	121 +	Total
11	ALDER,JACOB K	3372319941	02/19/2003	500.00	200.00	125.00	250.00	-140.00	935.00
14	BRIDGES,JEFF	222222222		0.00	0.00	0.00	125.00	0.00	125.00
33	DAVIS,JOHNNY	5500980984		550.00	0.00	0.00	0.00	0.00	550.00
5	DEVERON,SEAN D	3374333099	03/17/2003	0.00	0.00	0.00	230.00	0.00	230.00
17	FRUGE,CINDY	3379879878		125.00	50.00	25.00	25.00	0.00	225.00
35	FUSILIER,AMBE	3234234234		350.00	0.00	0.00	0.00	0.00	350.00
9	FUSILIER,BRYAN	3372120724	06/17/2003	600.00	897.10	545.00	155.00	-90.00	2107.10
22	FUSILIER,BRYAN		03/28/2003	0.00	0.00	605.00	0.00	0.00	605.00
27	FUSILIER,BRYAN			500.00	200.00	0.00	0.00	0.00	700.00
28	FUSILIER,BRYAN			500.00	200.00	0.00	0.00	0.00	700.00
29	FUSILIER,BRYAN			500.00	200.00	0.00	0.00	0.00	700.00
32	FUSILIER,BRYAN	3333334343		500.00	100.00	0.00	0.00	0.00	600.00
36	FUSILIER,TONYA	2394877987	06/24/2003	350.00	0.00	0.00	0.00	0.00	350.00
				5645.00	2304.60	1445.00	1160.00	-30.00	10524.60
					53.64 %	21.90 %	13.73 %	11.02 %	-0.29 %

AGING REPORT (DETAILED)



Use this feature to generate a detailed account ageing report that includes balances separate for patient responsible, primary, secondary, and third insurances. The report will include the **PATIENT'S NAME**, **PAY SOURCE** (**PRIMARY**) (**SECONDARY**) (**THIRD**) **INSURANCE NAME**, and the **OUTSTANDING BALANCE** showing the **AGEING STATUS**.

SAMPLE AGEING REPORT (DETAILED):

```
** DETAILED ACCOUNT AGEING REPORT AS OF 06/24/2003 ALL PROVIDERS
Page   1

Acct # Name          Current   31 - 60   61 - 90   91 -120     121 +     Total    Ins.Bal
================================================================================================
     8 ALDER, JACOB   500.00    200.00      0.00    250.00   -140.00    810.00
       BLUE CROSS       0.00      0.00    125.00      0.00      0.00    125.00
       BLUE CROSS       0.00      0.00      0.00      0.00      0.00      0.00
                        0.00      0.00      0.00      0.00      0.00      0.00    125.00

    14 BRIDGES, JEFF    0.00      0.00      0.00      0.00      0.00      0.00
       BLUE CROSS       0.00      0.00      0.00    125.00      0.00    125.00
       AETNA            0.00      0.00      0.00      0.00      0.00      0.00
                        0.00      0.00      0.00      0.00      0.00      0.00    125.00

    33 DAVIS, JOHNNY  400.00      0.00      0.00      0.00      0.00    400.00
       CIGNA          150.00      0.00      0.00      0.00      0.00    150.00
       BLUE CROSS       0.00      0.00      0.00      0.00      0.00      0.00
                        0.00      0.00      0.00      0.00      0.00      0.00    150.00

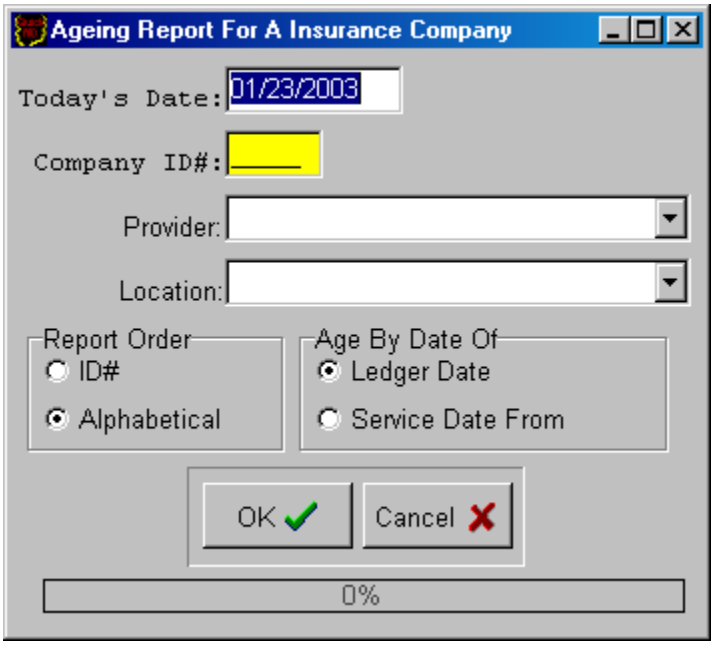
     5 DEVERON, SEAN    0.00      0.00      0.00      0.00      0.00      0.00
       MEDICAID         0.00      0.00      0.00    230.00      0.00    230.00
                        0.00      0.00      0.00      0.00      0.00      0.00
                        0.00      0.00      0.00      0.00      0.00      0.00    230.00

    17 FRUGE, CINDY   125.00     50.00     25.00     25.00      0.00    225.00
       AETNA            0.00      0.00      0.00      0.00      0.00      0.00
       BLUE CROSS       0.00      0.00      0.00      0.00      0.00      0.00
                        0.00      0.00      0.00      0.00      0.00      0.00      0.00

    ------------------------------------------------------------------------------------------PRIMAR
Y INSURANCE $   845.00    750.00   1330.00    740.00      0.00   3665.00
SECONDARY INSURANCE $ 150.00    314.60      0.00      0.00    100.00    564.60
THIRD INSURANCE $       0.00      0.00      0.00      0.00      0.00      0.00
PATIENT $            4650.00   1240.00    115.00    420.00   -130.00   6295.00

                                                                          ==========
                                                                           10524.60
```

Ageing Report (for one insurance company)



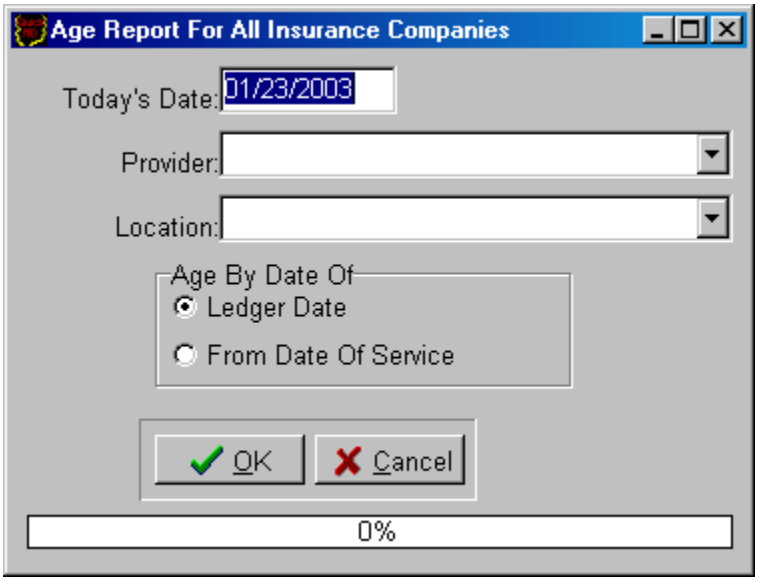
Use this feature to generate an aged account's receivable report for the selected Insurance Company with the **Patient's name**, **claim number**, and any **outstanding balance**.

Sample Ageing Report (For one Insurance Company):

AGEING REPORT FOR :AETNA AS OF:06/24/2003 Page # 1

ID#	Patient Name	Clm#	Current	Over 30	Over 60	Over 90	Over 120
9	FUSILIER, BRYAN	11	0.00	0.00	0.00	30.00	0.00
9	FUSILIER, BRYAN	12	0.00	0.00	0.00	125.00	0.00
9	FUSILIER, BRYAN	16	0.00	0.00	100.00	0.00	0.00
9	FUSILIER, BRYAN	17	0.00	0.00	125.00	0.00	0.00
9	FUSILIER, BRYAN	18	0.00	0.00	125.00	0.00	0.00
9	FUSILIER, BRYAN	19	0.00	0.00	125.00	0.00	0.00
9	FUSILIER, BRYAN	21	0.00	125.00	0.00	0.00	0.00
9	FUSILIER, BRYAN	22	0.00	125.00	0.00	0.00	0.00
9	FUSILIER, BRYAN	26	0.00	250.00	0.00	0.00	0.00
9	FUSILIER, BRYAN	27	0.00	100.00	0.00	0.00	0.00
9	FUSILIER, BRYAN	29	125.00	0.00	0.00	0.00	0.00
	GRAND TOTAL $		1355.00	125.00	600.00	475.00	155.00	0.00

Aging Report (All Insurance Companies)



Use this feature to generate an account's receivable aging report of all Insurance Companies. The report list all Insurance companies, by ID, and each patient that has that insurance and his aged trail balance. A wonderful report to see what insurances your patient base has, and how well they are paying you.

Sample Ageing Report (For All Insurance Companies):

AGEING REPORT BY INSURANCE COMPANY 06/24/2003 Page # 1

COMPANY # 4 AETNA

Acct #	Patient Name	Current	Over 30	Over 60	Over 90	Over 120	Total
9	FUSILIER, BRYAN	125.00	600.00	475.00	155.00	0.00	1355.00
34	JOHNSON, AMBER	150.00	0.00	0.00	0.00	0.00	150.00
		275.00	600.00	475.00	155.00	0.00	1505.00

COMPANY # 3 BLUE CROSS

Acct #	Patient Name	Current	Over 30	Over 60	Over 90	Over 120	Total
8	ALDER, JACOB	0.00	0.00	125.00	0.00	0.00	125.00
14	BRIDGES, JEFF	0.00	0.00	0.00	125.00	0.00	125.00
22	FUSILIER, BRYAN	0.00	0.00	605.00	0.00	0.00	605.00
18	JONES, JIMMY	0.00	0.00	125.00	0.00	0.00	125.00
31	KRAMER, KEITH	0.00	67.50	0.00	0.00	0.00	67.50
15	SMITH, KIRK	0.00	0.00	0.00	230.00	0.00	230.00
		0.00	67.50	855.00	355.00	0.00	1277.50

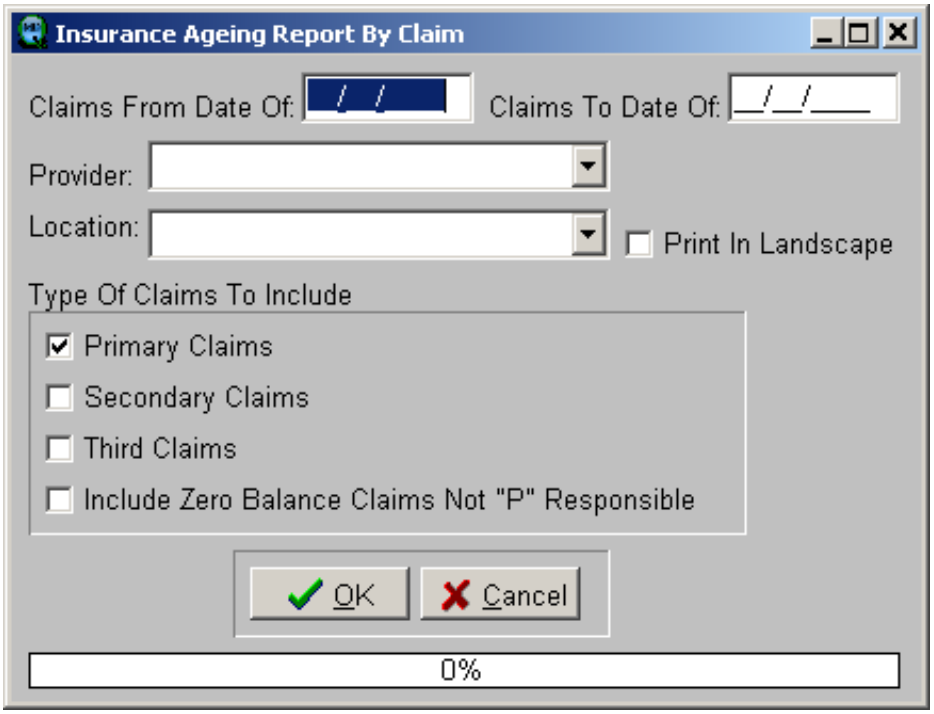
COMPANY # 6 CIGNA

Acct #	Patient Name	Current	Over 30	Over 60	Over 90	Over 120	Total
33	DAVIS, JOHNNY	150.00	0.00	0.00	0.00	0.00	150.00
35	FUSILIER, AMBER	150.00	0.00	0.00	0.00	0.00	150.00
9	FUSILIER, BRYAN	0.00	172.10	0.00	0.00	100.00	272.10
34	JOHNSON, AMBER	120.00	0.00	0.00	0.00	0.00	120.00
31	KRAMER, KEITH	0.00	150.00	0.00	0.00	0.00	150.00
		420.00	322.10	0.00	0.00	100.00	842.10

COMPANY # 2 MEDICAID

Acct #	Patient Name	Current	Over 30	Over 60	Over 90	Over 120	Total
5	DEVERON, SEAN	0.00	0.00	0.00	230.00	0.00	230.00
		0.00	0.00	0.00	230.00	0.00	230.00

Ageing Report (By Claim)



Use this feature to generate an ageing report by claim type, provider, and location, for a certain date range. If you wanted to see an ageing report of all of your secondary claims within in a certain date range, you would check the box labeled “Secondary Claims” choose your date range and then click OK.

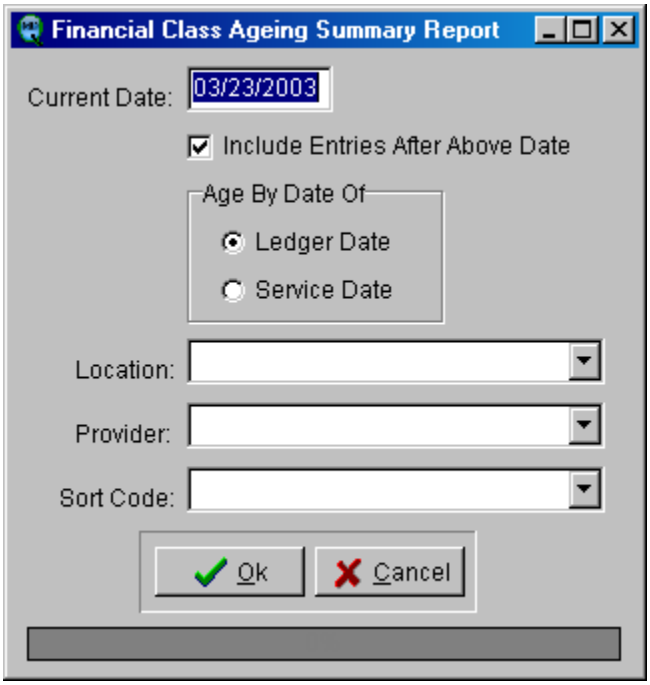
Sample Ageing Report (By Claim):

```
Office :GOODFELLOW CLINIC
INSURANCE AGEING REPORT BY CLAIM FROM 01/01/2005 TO 06/08/2005 Page #   2
Acct # Patient Name                          Clm#       Responsible Party At This Time
  Current   Over 30   Over 60   Over 90  Over 120
================================================================================================================
    10 WHITE, LISA R                          1  #    0
     0.00      0.00      0.00   1350.00      0.00      Primary Co.   Date of Claim 02/16/2005

    10 WHITE, LISA R                          2  #    0
     0.00      0.00      0.00    500.00      0.00      Primary Co.   Date of Claim 02/16/2005

----------------------------------------------------------------------------------------------------------------
   636.00      0.00   1175.00   4800.20   1000.00   GRAND TOTAL $   7611.20
```

Financial Class Ageing Summary Report



Use this feature to generate an ageing report by Financial Class.

SAMPLE FINANCIAL CLASS AGEING REPORT:

FINANCIAL SUMMARY AGEING BASED ON DATE 06/24/2003 Page # 1

1 MEDICARE

Resp	Current	Over 30	Over 60	Over 90	Over 120	Total
P.Ins	725.00	750.00	1205.00	510.00	0.00	3190.00
S.Ins	0.00	239.60	0.00	0.00	100.00	339.60
T.Ins	0.00	0.00	0.00	0.00	0.00	0.00
Pat	3350.00	915.00	115.00	170.00	-190.00	4360.00
	4075.00	1904.60	1320.00	680.00	-90.00	7889.60

2 MEDICAID

Resp	Current	Over 30	Over 60	Over 90	Over 120	Total
P.Ins	0.00	0.00	0.00	230.00	0.00	230.00
S.Ins	0.00	0.00	0.00	0.00	0.00	0.00
T.Ins	0.00	0.00	0.00	0.00	0.00	0.00
Pat	500.00	200.00	0.00	0.00	0.00	700.00
	500.00	200.00	0.00	230.00	0.00	930.00

3 BLUE CROSS

Resp	Current	Over 30	Over 60	Over 90	Over 120	Total
P.Ins	0.00	0.00	0.00	0.00	0.00	0.00
S.Ins	0.00	0.00	0.00	0.00	0.00	0.00
T.Ins	0.00	0.00	0.00	0.00	0.00	0.00
Pat	0.00	0.00	0.00	0.00	200.00	200.00
	0.00	0.00	0.00	0.00	200.00	200.00

4 AETNA

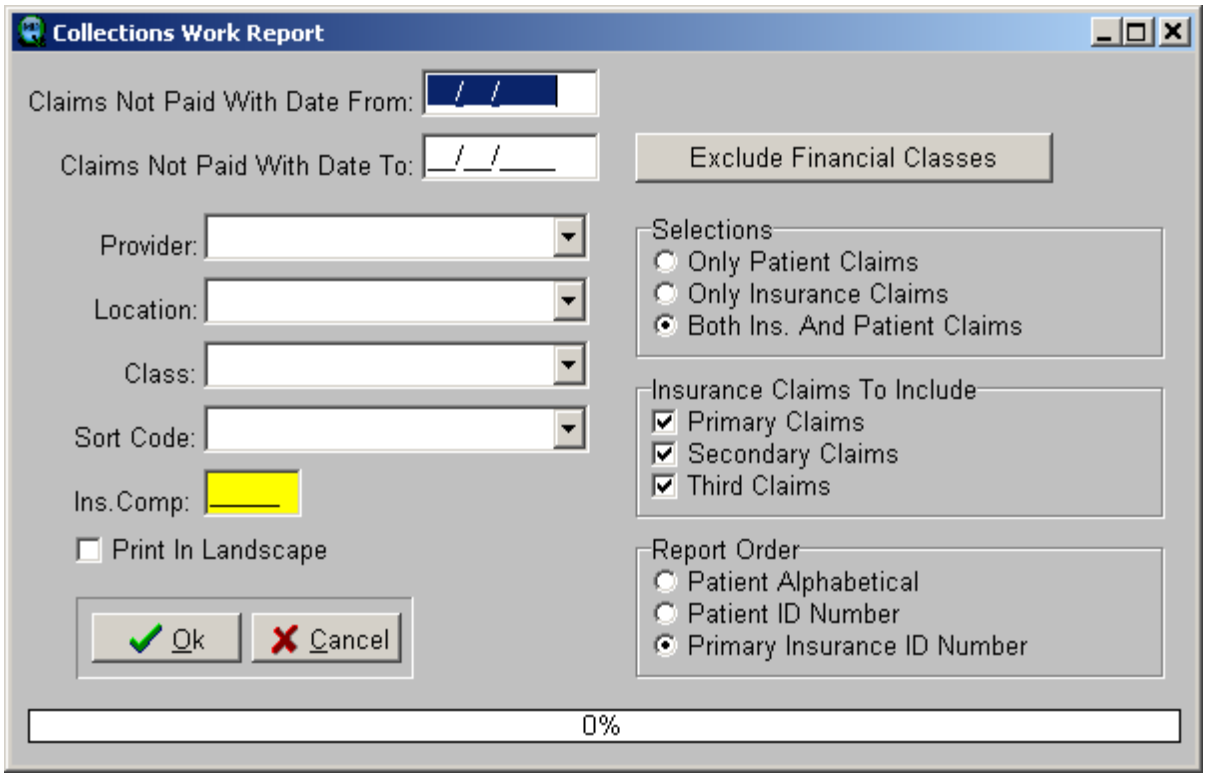
Resp	Current	Over 30	Over 60	Over 90	Over 120	Total
P.Ins	120.00	0.00	0.00	0.00	0.00	120.00
S.Ins	150.00	0.00	0.00	0.00	0.00	150.00
T.Ins	0.00	0.00	0.00	0.00	0.00	0.00
Pat	300.00	0.00	0.00	0.00	0.00	300.00
	570.00	0.00	0.00	0.00	0.00	570.00

GRAND TOTALS

Resp	Current	Over 30	Over 60	Over 90	Over 120	Total
P.Ins	845.00	750.00	1330.00	740.00	0.00	3665.00
S.Ins	150.00	239.60	0.00	0.00	100.00	489.60
T.Ins	0.00	0.00	0.00	0.00	0.00	0.00
Pat	4650.00	1315.00	115.00	420.00	-130.00	6370.00
GT	5645.00	2304.60	1445.00	1160.00	-30.00	10524.60

Collections Work Report

Use this feature to generate a report containing all information required to effectively work you practice's collections. The report generates all pertinent Patient, Claim and Insurance Information necessary to work past due accounts without ever having to leave your chair to gather charts, phone numbers, etc. etc. Simply enter the date range of old accounts that you wish to work, select your parameters (you may even exclude financial class(s) And hit OK. No more chasing charts!



SAMPLE COLLECTIONS WORK REPORT:

```
Collections Work Report 06/24/2003  Page #   1
================================================================================
ID#     4 DEBRA A TURNER H.P:337-434-2030 W.P:337-469-5013 EXT  SS#433-11-8066
2234 LA GRANGE  LAKE CHARLES, LA 70601 DOB:10/20/1965
Prim Ins : Pol#23423409 Grp#5390934
Sec Ins  : Pol# Grp#
Third Ins: Pol# Grp#
Guarantor:DEBRA A TURNER
Responsibility Of Claim At This Time :P
DEBRA A TURNER
H.Phone:337-434-2030  W.Phone:337-469-5013 Ext:

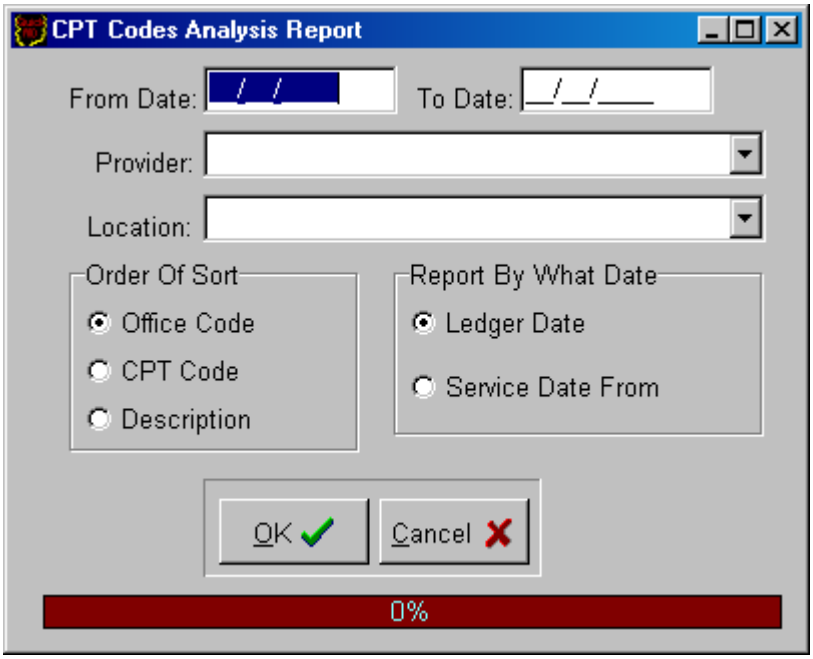
Date       Clm# Inv# Resp Description                    Prim.Diag Units  Amount
--------------------------------------------------------------------------------
01/24/2003    2    1 P    NEW OFFICE VISIT               789.0     1.0   200.00
--------------------------------------------------------------------------------
                                                                        200.00

ID#    36 TONYA  LYNN FUSILIER H.P:239-487-7987 W.P: EXT  SS#987-34-9587
PO BOX 3131  NEW ORLEANS, LA 70128 DOB:01/01/1970
Prim Ins: MEDICARE Pol#987349587 Grp#
Historical Ins.Company  :MEDICARE In effect Until :06/24/2003
Sec Ins:AETNA Pol#987349587 Grp#
Third Ins: Pol# Grp#
Guarantor:JEANATTORNEYATL JOHN
Responsibility Of Claim At This Time :P
JEANATTORNEYATL JOHN
H.Phone: 337-499-1313
H.Phone: 337-499-1313

Date       Clm# Inv# Resp Description                    Prim.Diag Units  Amount
--------------------------------------------------------------------------------
06/24/2003    1    1 P    CONTRACT BILLING                          1.0   100.00
--------------------------------------------------------------------------------
                                                                        100.00

ID#    36 TONYA  LYNN FUSILIER H.P:239-487-7987 W.P: EXT  SS#987-34-9587
PO BOX 3131  NEW ORLEANS, LA 70128 DOB:01/01/1970
Prim Ins :MEDICARE Pol#987349587 Grp#
Historical Ins.Company  :MEDICARE In effect Until :06/24/2003
Sec Ins  :AETNA Pol#987349587 Grp#
Third Ins: Pol# Grp#
Guarantor:JEANATTORNEYATL JOHN
Responsibility Of Claim At This Time :I
ID#    1 MEDICARE Phn#800-222-0155 Contact:JACK SANDERS
PO BOX 789  JACKSON, MS 75589
Subsciber:TONYA  FUSILIER SS#987-34-9587 DOB:01/01/1970
Date       Clm# Inv# Resp Description                    Prim.Diag Units  Amount
--------------------------------------------------------------------------------
06/24/2003    2    1 I    OFFICE VISIT - NEW                        1.0   150.00
--------------------------------------------------------------------------------
                                                                        150.00
```

CPT CODES ANALYSIS REPORT



Use this feature to generate a report on the total units and total dollar amount generated on every CPT Codes that was utilized during the time frame selected. The report generated will contain the following fields: **HOUSE CODE**, **CPT CODE**, **DESCRIPTION**, **# OF UNITS OR TIMES THIS WAS UTILIZED**, **TOTAL DOLLARS THIS CODE GENERATED**, **AVERAGE DOLLAR AMOUNT PER TIME USED**, and **PERCENTAGE (%) OF YOUR TOTAL PRACTICE REVENUE THIS CODE REPRESENTS. A WONDERFUL REPORT FOR ANALIZING YOUR PARACTICE!**

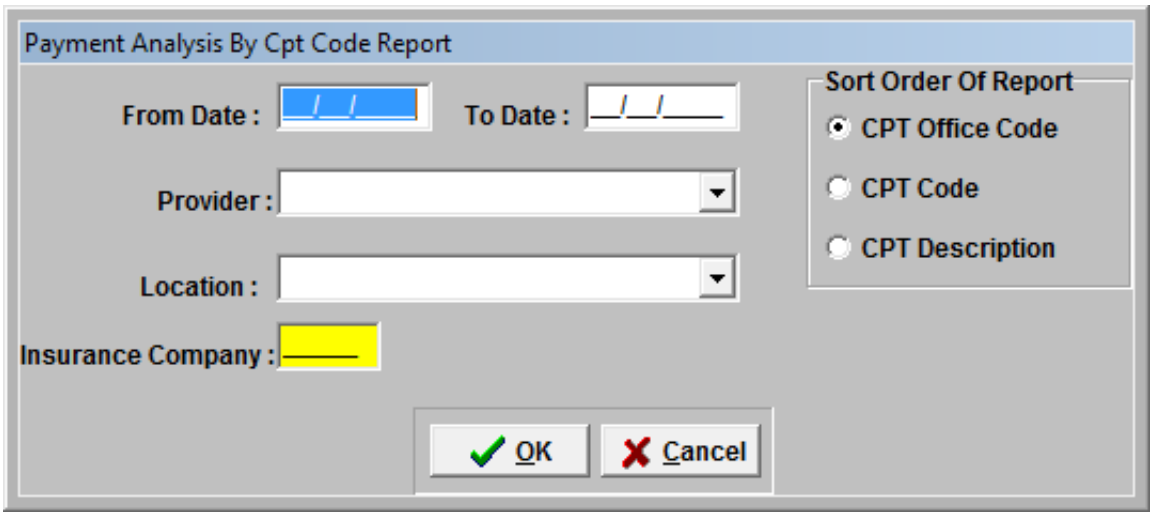
SAMPLE CPT CODES ANALYSIS REPORT:

CPT CODES ANALYSIS FOR ALL PROVIDERS 01/01/2003 To 06/24/2003
Page # 1

CODE	CPT CODE	DESCRIPTION	#UNITS	TOTAL $	AVG. $	% TOT
100	100	NEW OFFICE VISIT	3.00	200.00	66.67	1.36
15MIN	9999999	15 MINUTE	1.00	125.00	0.00	0.00
90801	90801	PSYCH EVAL	4.00	495.00	123.75	3.37
99212	99212	OFFICE VISIT	8.00	800.00	100.00	5.44
99225	99225	OFFICE VISIT - NEW	37.00	6700.00	181.08	45.58
CONTRC	CONTRCT	CONTRACT BILLING	79.00	6505.00	82.34	44.25
CREDIT	CREDIT	PATIENT OVERPAYMENT	2.00	0.00	0.00	0.00

14700.00

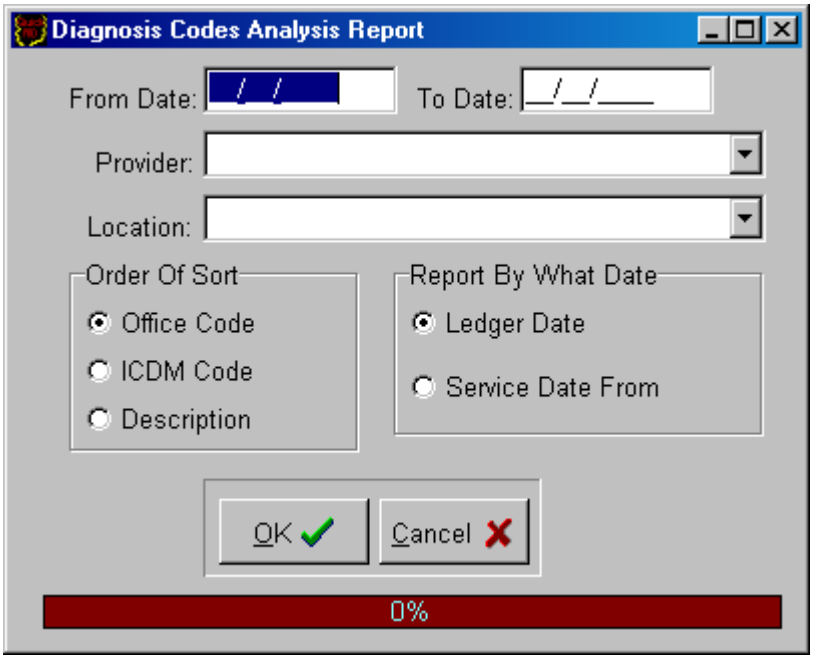
Payment Analysis By Cpt Code Report



This report show the amount of money collected, number of units, average per until and percentage of the grand total for all procedure codes during a date range. The results of report can be limited by Provider, Location or Insurance Company.

```
PAYMENT ANALYSIS BY CPT CODE FROM :01/01/2011 TO :07/15/2011       Page # 1
OffCode CPT Code          Description                    # Units     $ Total  $ Average % Of Total
================================================================================================
41520   41520             FRENOPLASTY W/Z-PLASTY            1.00        5.00       5.00    2.63%
42831   42831             ADENOIDECTOMY OVER 12 PRIMARY     1.00       25.00      25.00   13.16%
99241   99241             OFFICE CONSULT FOCUSED            1.00       10.00      10.00    5.26%
CREDIT  CREDIT            SURGERY DEPOSIT                   1.00      150.00     150.00   78.95%
                                                                    ==========
                                                                       190.00
```

Diagnosis Codes Analysis

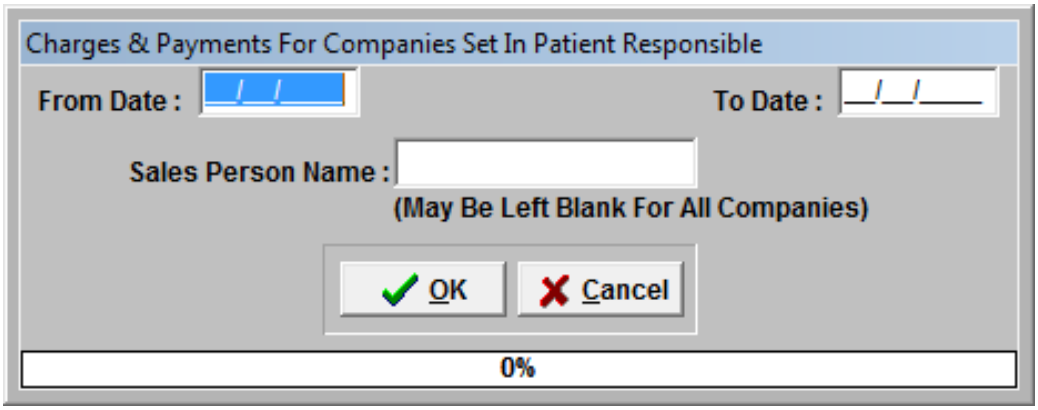


Use this feature to generate a report on the total number of Patients and the total dollar amount generated for the selected dates on each Diagnosis Code utilized. Since more than one diagnosis code may be used with a Procedure code, the dollar amounts generated in this report or for reference only and not to be used in the accounting process.

Sample Diagnosis Codes Analysis Report:

```
                                                                        Page #  1
DIAGNOSIS CODES ANALYSIS FOR ALL PROVIDERS 01/01/2003 To 06/24/2003
CODE    ICDM #    DESCRIPTION                        TOTAL  $  % TOT   PATIENTS
================================================================================
100     100       LEPTOSPIROSIS                       3050.00  32.46      14
100.8   100.8     OTHER SPECIFIED LEPTOSPIRAL IN      2150.00  22.88       1
100.81  100.81    LEPTOSPIRAL MENINGITIS (ASEPTI       850.00   9.05       2
100.89  100.89    OTHER SPECIFIED LEPTOSPIRAL IN       125.00   1.33       1
100.9   100.9     LEPTOSPIROSIS, UNSPECIFIED          1295.00  13.78       3
101     101       VINCENT'S ANGINA                     125.00   1.33       1
102     102       YAWS                                 425.00   4.52       2
102.0   102.0     INITIAL LESIONS OF YAWS              150.00   1.60       1
441.3   441.3     ABDOMINAL ANEURYSM, RUPTURED         200.00   2.13       1
789.0   789.0     ABDOMINAL PAIN                       325.00   3.46       2
789.32  789.0     ABDOMINAL PAIN                       700.00   7.45       4
--------------------------------------------------------------------------------
                                                     9395.00
```

Charge & Payment For Companies Set In Patient Responsible



This report will give you the total charged and collected during a time period for all companies or for companies that have a sales person associated with them.

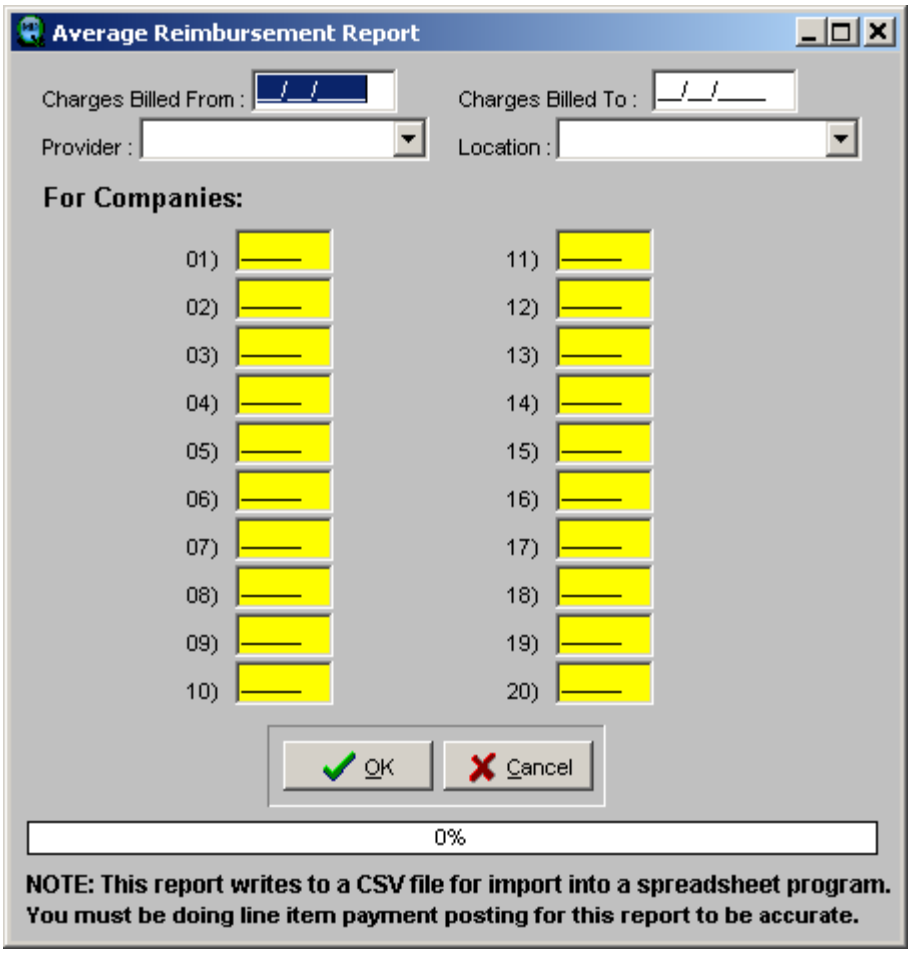
To associate a sales person with a company you add the sales person's name in the comment field of the employer record and check the box labeled "This Company is an Employer" has to be checked. (For more info see Add Insurance Record55)

Only items for Patients that have a company as the guarantor, have the 'P' responsibility on the charge and payment and have payments and charges in the specified date range will show up on the report. (For more information on guarantors see 31. For responsibilities is 26)

```
CHARGES & PAYMENTS FROM:07/01/2011 TO:07/15/2011  Page # 1
FOR : JANE DOE
     COMPANY NAME                                          $ INVOICED $COLLECTED
================================================================================
   1 WALMART                                                 1435.00     550.00
================================================================================
                                                             1435.00     550.00
```

Average Reimbursement Report

This report allows you to see each insurance company's reimbursement rate, by unit, for each procedure billed in a certain date range. For this report to be of any value to the office, the office must be posting their payments by invoice.



To run the report enter a date range, the Provider and location are optional, and setup the insurance companies that you want information about. When the report is ran Quick-MD will ask you for a filename. The file and location that you pick is where the data will be written. To view this information in a spread sheet, such as excel, you will need to open the file that you just saved from within the spread sheet application.

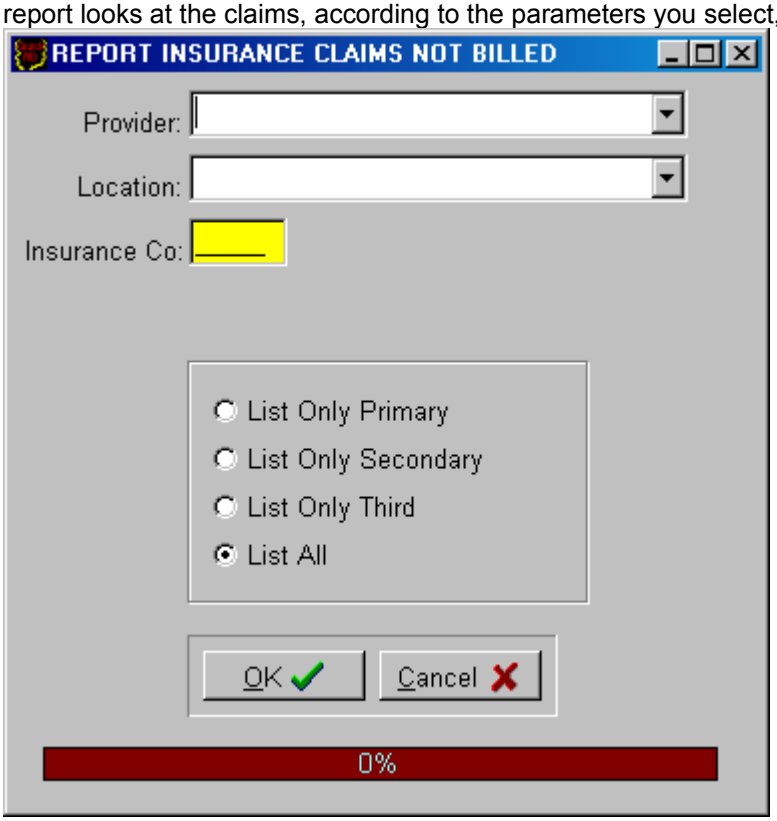
Sample Reimbursement Report

```
AVERAGE REIMBURSEMENT REPORT FROM 07/12/2005 THRU 07/12/2005,
CPT CODE,NOBLE DRILLING,MEDICAID,U.O.S.DONE,
99243,           90.00,          160.00,           30.00,
```

The layout will always be the CPT code in the first column, followed by a column for each insurance company, then the total number of units for that procedure.

Insurance Claims Not Billed

Use this feature to generate a report on the list of Patients and their Insurance claims that have not been billed. This report looks at the claims, according to the parameters you select, that do not have a *red billing note* on them.



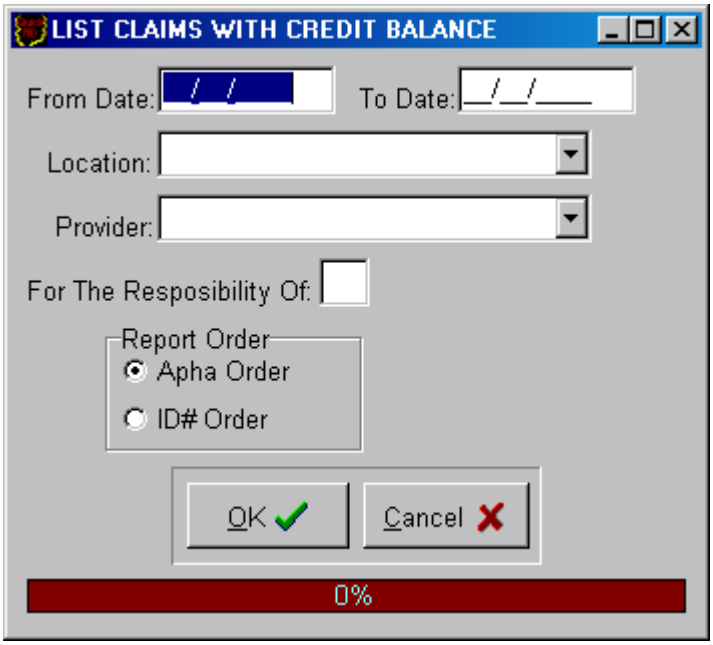
The report generated contains the following fields: **Id#, Patient Name**, **Insurance Kind** *(primary, secondary, third),* **Insurance Code**, **Insurance Company**.

Sample Insurance Claims Not Billed Report:

```
INSURANCE CLAIMS NOT BILLED AS OF 06/24/2003   Page # 1

ID#    PATIENT NAME        INS.KIND    ICODE INSURANCE COMPANY    DATE       CLM#   $ BALANCE
=============================================================================================
9      FUSILIER, BRYAN      Secondary      6 CIGNA              02/12/2003    1      100.00
     9 FUSILIER, BRYAN      Secondary      6 CIGNA              02/12/2003    3      125.00
     9 FUSILIER, BRYAN      Secondary      6 CIGNA              02/19/2003    4      100.00
     9 FUSILIER, BRYAN      Primary        4 AETNA              02/12/2003   13      100.00
     9 FUSILIER, BRYAN      Secondary      6 CIGNA              02/12/2003   13      100.00
     9 FUSILIER, BRYAN      Secondary      6 CIGNA              05/13/2003   23      125.00
     9 FUSILIER, BRYAN      Primary        4 AETNA              05/22/2003   26      250.00
     9 FUSILIER, BRYAN      Primary        4 AETNA              05/22/2003   27      100.00
     9 FUSILIER, BRYAN      Primary        4 AETNA              06/05/2003   29      125.00
    31 KRAMER, KEITH        Secondary      3 BLUE CROSS         05/19/2003    1      150.00
    33 DAVIS, JOHNNY        Primary        6 CIGNA              06/11/2003    4      150.00
    34 JOHNSON, AMBER       Primary        6 CIGNA              06/17/2003    2      150.00
    34 JOHNSON, AMBER       Primary        6 CIGNA              06/17/2003    3      120.00
    35 FUSILIER, AMBER      Primary        6 CIGNA              06/17/2003    2      150.00
    36 FUSILIER, TONYA      Primary        1 MEDICARE           06/24/2003    2      150.00
    36 FUSILIER, TONYA      Primary        1 MEDICARE           06/24/2003    3      150.00
---------------------------------------------------------------------------------------------
TOTAL PRIMARY CLAIMS   :   10 $1445.00
TOTAL SECONDARY CLAIMS :    6 $ 700.00
TOTAL ATT/THIRD CLAIMS :    0 $   0.00
---------------------------------------------------------------------------------------------
TOTALS FOR ALL CLAIMS  :   16 $2145.00
```

Claims With Credit Balances



Use this feature to generate a report on the list of Patient's and the claim number that have a credit balance. A credit balance occurs when an overpayment has been posted to a claim. If the claim has a "P" responsibility attached to it, the credit will be reflected in the patient's un-applied credit. If the claim carries an I, S or A responsibility, the credit will be for the insurance company.

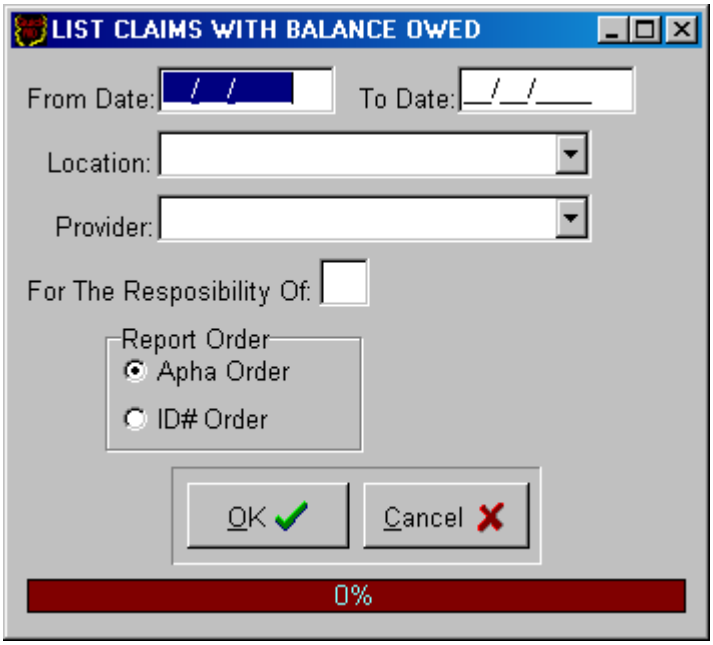
Sample Claims with Credit Balances Report:

```
CLAIMS WITH A CREDIT BALANCE AS :01/01/2003 TO:06/24/2003 PAGE #   1

ID#    Patient Name              CLM# $  Balance   Responsibility
================================================================================
     8 ALDER, JACOB                 2    -290.00   ALDER, JACOB
     9 FUSILIER, BRYAN             10    -190.00   FUSILIER, BRYAN
    36 FUSILIER, TONYA              5     -50.00   FUSILIER, TONYA
--------------------------------------------------------------------------------
                                          -530.00

TOTAL CLAIMS WITH CREDIT BALANCE -->    3
```

Claims With Balance Owed



Use this feature to generate a claims report that have unpaid balances, by date range and responsibility. The report lists the Patient's name, claim number, the balance owed, and the responsible party name. This feature allows the user to track all claims that have not been paid in full.

Sample Claims with Balance Owed Report:

```
CLAIMS WITH A BALANCE OWED AS :01/01/2003 TO:06/24/2003 PAGE #   1

ID#     Patient Name    CLM# $  Balance Responsibility   Ledg.Date  Last Paymt
================================================================================
     8 ALDER, JACOB     3      150.00 ALDER, JACOB        02/19/2003 02/19/2003
     8 ALDER, JACOB     4      125.00 ALDER, JACOB        03/11/2003 02/19/2003
     8 ALDER, JACOB     5      125.00 ALDER, JACOB        03/11/2003 02/19/2003
     8 ALDER, JACOB     6      125.00 BLUE CROSS          04/17/2003 02/19/2003
     8 ALDER, JACOB     7      100.00 ALDER, JACOB        05/19/2003 02/19/2003
     8 ALDER, JACOB     8      100.00 ALDER, JACOB        05/22/2003 02/19/2003
     8 ALDER, JACOB     9      100.00 ALDER, JACOB        06/11/2003 02/19/2003
     8 ALDER, JACOB    10      100.00 ALDER, JACOB        06/11/2003 02/19/2003
     8 ALDER, JACOB    11      100.00 ALDER, JACOB        06/17/2003 02/19/2003
     8 ALDER, JACOB    12      100.00 ALDER, JACOB        06/17/2003 02/19/2003
     8 ALDER, JACOB    13      100.00 ALDER, JACOB        06/24/2003 02/19/2003
    14 BRIDGES, JEFF    1      125.00 BLUE CROSS          03/17/2003
    33 DAVIS, JOHNNY    3      100.00 DAVIS, JOHNNY       06/11/2003
    33 DAVIS, JOHNNY    4      150.00 CIGNA               06/11/2003
    33 DAVIS, JOHNNY    5      100.00 DAVIS, JOHNNY       06/17/2003
    33 DAVIS, JOHNNY    6      100.00 DAVIS, JOHNNY       06/17/2003
    33 DAVIS, JOHNNY    7      100.00 DAVIS, JOHNNY       06/24/2003
     5 DEVERON, SEAN    2      105.00 MEDICAID            03/17/2003 03/17/2003
     5 DEVERON, SEAN    3      125.00 MEDICAID            03/17/2003 03/17/2003
    17 FRUGE, CINDY     1       25.00 FRUGE, CINDY        03/21/2003
--------------------------------------------------------------------------------
                              1955.00

TOTAL CLAIMS WITH BALANCE OWED -->  20
```

Managed Care Expirations



Use this feature to generate a report that shows all of the authorizations, listed in the patient's managed care module, that have expired during a time period that you specify.

Sample Managed Care Expirations Report:

```
RECEIVED REF.PHY.EXPIRATIONS FROM 10/01/2003 TO 06/08/2005 FOR:JOHN SMITH  Page Number :
5
Pat ID Patient Name              Valid Dates           Visits Days Remain P.O.Number
Referring Phy/Primary Insurance
================================================================================
   217                           10/28/2003-04/28/2004   99         0     1797995
HARRIS MCILWAIN MD
                                                       Remaining Vists =  99

   218                           10/28/2003-05/28/2004   99         0     144758
JOEL MATTISON MD
                                                       Remaining Vists =  99

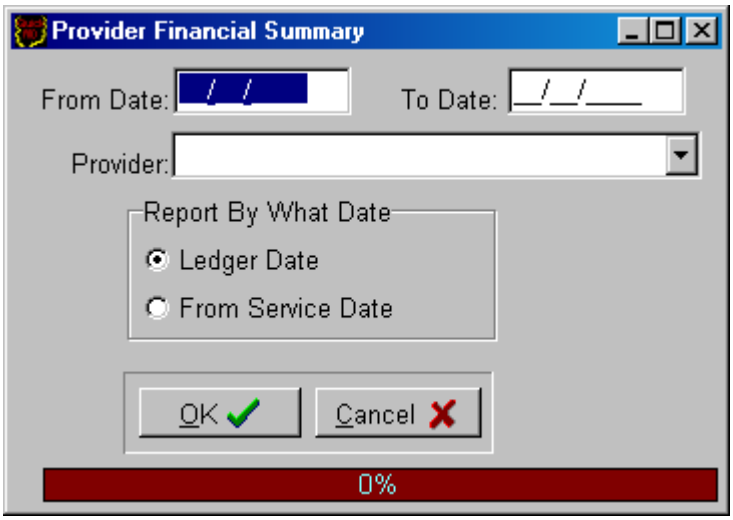
   221                           10/30/2003-04/30/2004   99         0     1797995
HARRIS MCILWAIN MD
                                                       Remaining Vists =  99

   226                           10/30/2003-04/30/2004   99         0     1948195
VINCENT K FARRIER
                                                       Remaining Vists =  99

   227                           10/29/2003-04/29/2004   99         0     1797995
HARRIS MCILWAIN MD
                                                       Remaining Vists =  99

   229                           10/31/2003-04/30/2004   99         0     1940828
REF.PHY.NOT SET
                                                       Remaining Vists =  99
```

Financial Summary For Providers



Use this feature to generate a Financial Report for a selected date range showing the total charges, number of charges, payments received, credit and debit adjustments, receivable amount, and the overall collection percentage for each Provider, or for all providers if the provider field is left blank.
Valuable information that is so easy to run the Docs will even run it themselves!

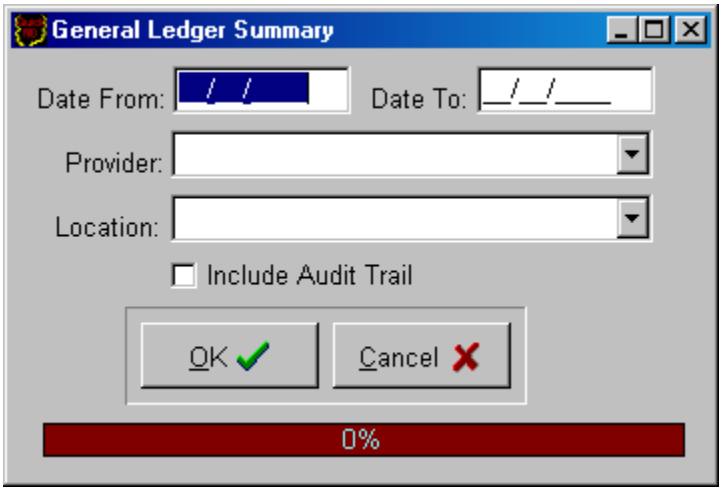
Sample Financial Summary For Providers Report:

```
FINANCIAL SUMMARY FOR PROVIDERS FROM 01/01/2003 TO 06/24/2003
Page    1

Provider           Charges #Chrgs   Payments Credit Adj  Debit Adj Receivable  Collection
%
================================================================================================
 1 JOHN A WILSON   14700.00    130   -2665.00   -2570.40     460.00    9924.60      17.58
------------------------------------------------------------------------------------------------
                   14700.00    130   -2665.00   -2570.40     460.00    9924.60      17.58


ADJUSTMENT SUMMARY                          PAYMENT SUMMARY
==================                          ===================
 1 PATIENT WRITEOFF          -2005.00        1  PATIENT CHECK                  -2415.00
 2 SELF PAY DISCOUNT             0.00        2  VISA/MASTERCARD                    0.00
 3 MEDICAID WRITE-OFF           -5.40        3  MEDICAID PAYMENT                -155.00
 4 MEDICARE WRITE-OFF            0.00        4  MEDICARE PAYMENT                 -75.00
 5 BLUE CROSS WRITE-OFF          0.00        5  BLUE CROSS PAYMENT               -20.00
 6 AETNA WRITE-OFF               0.00        6  AETNA PAYMENT                      0.00
 7 CIGNA                       460.00        7  CIGNA PAYMENT                      0.00
 8 COMMERCIAL WRITE OFF       -560.00        8  COMMERCIAL PAYMENT                 0.00
 9 OTHER                         0.00        9                                     0.00
10 TRANSFER OUT                  0.00       10                                     0.00
11 TRANSFER IN                   0.00       11                                     0.00
12 FROM UNAPPLIED CREDIT         0.00       12                                     0.00
13 UNAPPLIED PYMT TO ACCT.       0.00       13                                     0.00
```

General Ledger Summary



Use this feature to generate a General Ledger Report for a selected date range, listing the total amount received for each payment and adjustment type and their General Ledger Code.

SAMPLE GENERAL LEDGER SUMMARY REPORT:

CHARGES FROM :01/01/2003 TO :06/24/2003 Page # 1

Date	Pat ID	Cnum	Inum	Description	$ Amount	GL Code
01/17/2003	8	2	1	OFFICE VISIT	100.00	40002000
01/24/2003	4	2	1	NEW OFFICE VISIT	200.00	
02/12/2003	9	1	1	OFFICE VISIT	100.00	40002000
02/12/2003	9	2	1	OFFICE VISIT	100.00	40002000
02/12/2003	9	3	1	OFFICE VISIT - NEW	125.00	40002000
02/12/2003	9	13	3	OFFICE VISIT	100.00	40002000
02/17/2003	11	1	1	NEW OFFICE VISIT	0.00	
02/19/2003	8	3	1	OFFICE VISIT - NEW	125.00	40002000
02/19/2003	8	3	2	OFFICE VISIT	100.00	40002000
02/19/2003	9	7	1	OFFICE VISIT - NEW	125.00	40002000
					1075.00	

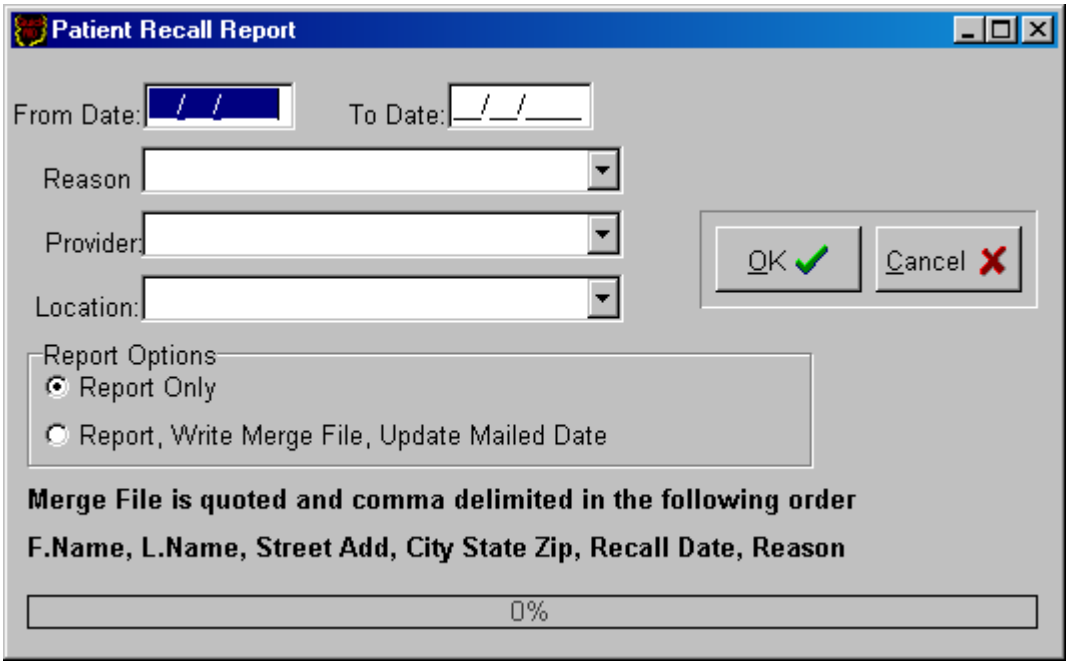
PAYMENTS FROM :01/01/2003 TO :06/24/2003 Page # 4

Date	Pat ID	Cnum	Inum	Description	$ Amount	GL Code
01/17/2003	8	2	1	PATIENT CHECK	-20.00	
01/17/2003	8	1	1	PATIENT CHECK	-20.00	
02/12/2003	9	1	1	BLUE CROSS PAYMENT	-75.00	
02/12/2003	9	1	1	COMMERCIAL PAYMENT	-20.00	
02/19/2003	8	1	1	PATIENT CHECK	-580.00	
02/19/2003	8	2	1	PATIENT CHECK	-420.00	
02/19/2003	8	3	1	PATIENT CHECK	-25.00	
02/19/2003	9	8	1	PATIENT CHECK	-200.00	
02/19/2003	9	2	1	PATIENT CHECK	-80.00	
					-1400.00	

ADJUSTMENTS FROM :01/01/2003 TO :06/24/2003 Page # 5

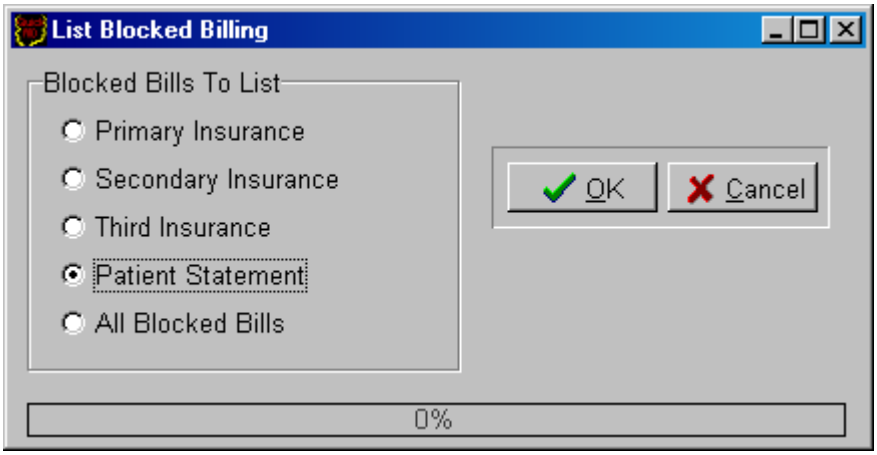
Date	Pat ID	Cnum	Inum	Description	$ Amount	GL Code	App. To
02/19/2003	8	2	1	TRANSFER OUT	50.00		99212
02/19/2003	9	8	1	TRANSFER OUT	100.00		CREDIT
02/19/2003	9	8	1	TRANSFER OUT	100.00		CREDIT
02/19/2003	9	10	1	TRANSFER OUT	25.00		CREDIT
02/19/2003	9	10	1	TRANSFER OUT	100.00		CREDIT
02/19/2003	9	10	1	TRANSFER OUT	30.00		CREDIT
02/19/2003	9	10	1	TRANSFER OUT	25.00		CREDIT
03/14/2003	9	10	1	TRANSFER OUT	30.00		CREDIT
					460.00		

Patient Recall Report



Use this feature to generate a report of the **Patient's name**, **recall date**, and the **reason for recall**. You may select report only or you may opt to send out letters by merging with a word processor. Quick-MD will put the date of the merge in each patients recall table (on the demographic screen).

List Blocked Bills



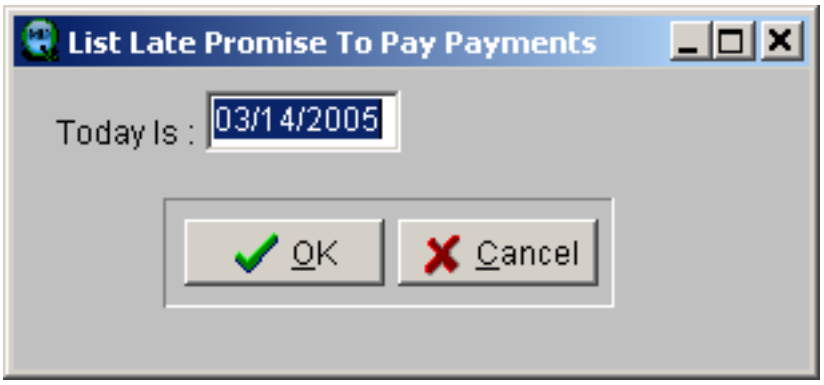
Use this feature to generate a report of all patients that have had their billing blocked. Blocking is accomplished by putting the appropriate responsibility code in the Block Bill box at the bottom right of the Patients demographic screen.

Sample List Blocked Bills Report:

```
Blocked Billing For All Responsibilities    Page #  1

   ID# Patient Name              Blocked Bill        Responsible`s Name
================================================================================
     5 SEAN DEVERON              Patient/Other       SEAN DEVERON
    11 BRENT FUSILIER            Primary Insurance   AETNA
    11 BRENT FUSILIER           Secondary Insurance BLUE CROSS
```

List Late Promise to Pay Payments



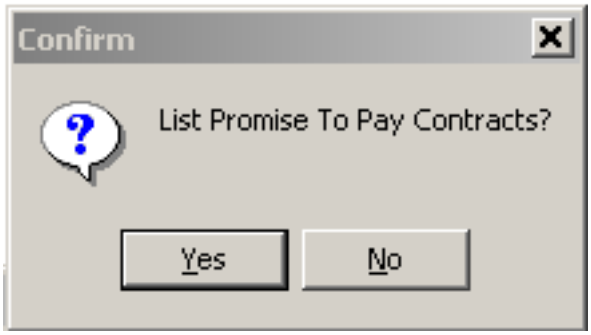
Use this feature to generate a report of all of the late **Promise to Pay** payments.

```
PROMISE TO PAY LATE REPORT FOR :03/14/2005  Page # 1
Act#   Patient              Due Date   $Expected  $Act.Pay  $Cont.Amt $Cont.Bal
================================================================================
     1 JANE DOE             03/01/2005    100.00      80.00   1200.00    920.00
THIS IS A PARTIAL PAYMENT

     2 DAVID SARGENT        03/01/2005    500.00       0.00   2000.00   2000.00
```

Act# - Patient's account number.
Patient – The patient's full name.
Due Date – Date that the payment was due.
$Expected – This is the expected amount of the patient.
$Act. Pay – Actual amount that was paid.
$Cont. Amt – This is the original Contract amount.
$Cont. Bal – This column contains the Contract balance.

List Promise to Pay Contracts



This report will show all of the promise to pay contracts in the system.

PROMISE TO PAY CONTRACTS LISTING :03/14/2005 Page # 1

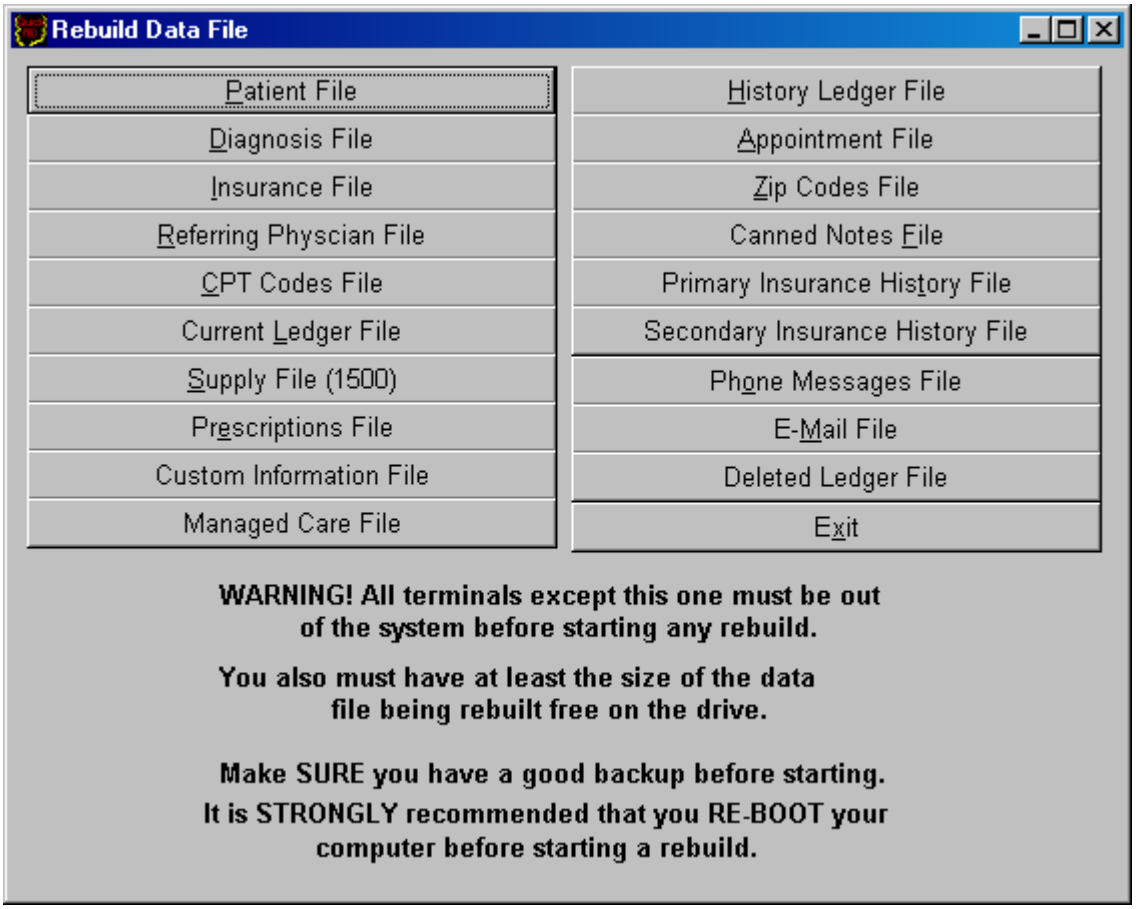
Act#	Patient	Cont.Amt	Tot.Pays	Status	Last Pay	$Cont.Bal
1	JANE DOE	1200.00	1200.00	ACTIVE	03/14/2005	0.00
2	DAVID SARGENT	2000.00	0.00	ACTIVE		2000.00
5	ROBERT LEUBNER	1200.27	0.00	ACTIVE		1200.27
7	BLANCHE MELTON	1200.27	0.00	ACTIVE		1200.27
8	JAYLIN MARTINEZ	850.00	0.00	ACTIVE		850.00
9	MARCIA STEWART	123.27	0.00	ACTIVE		123.27
12	SAVANNAH SINGLETON	1600.00	100.00	ACTIVE	02/23/2005	1500.00
13	KELSIE WARD	947.32	0.00	ACTIVE		947.32
14	CLAIRE PARKER	1200.00	0.00	ACTIVE		1200.00
15	JAMES SPIKES	1200.00	0.00	ACTIVE		1200.00
16	JODY SEAUX	2400.24	0.00	ACTIVE		2400.24
		13921.37				12621.37

Note: *Zero balance contracts will show up on the report if they are still active. You can set them to inactive on the promise to pay form. (for more information see page 184)*

ADVANCED FEATURES OF QUICK-MD

THE SYSTEM UTILITIES MENU

DATA FILES REBUILD

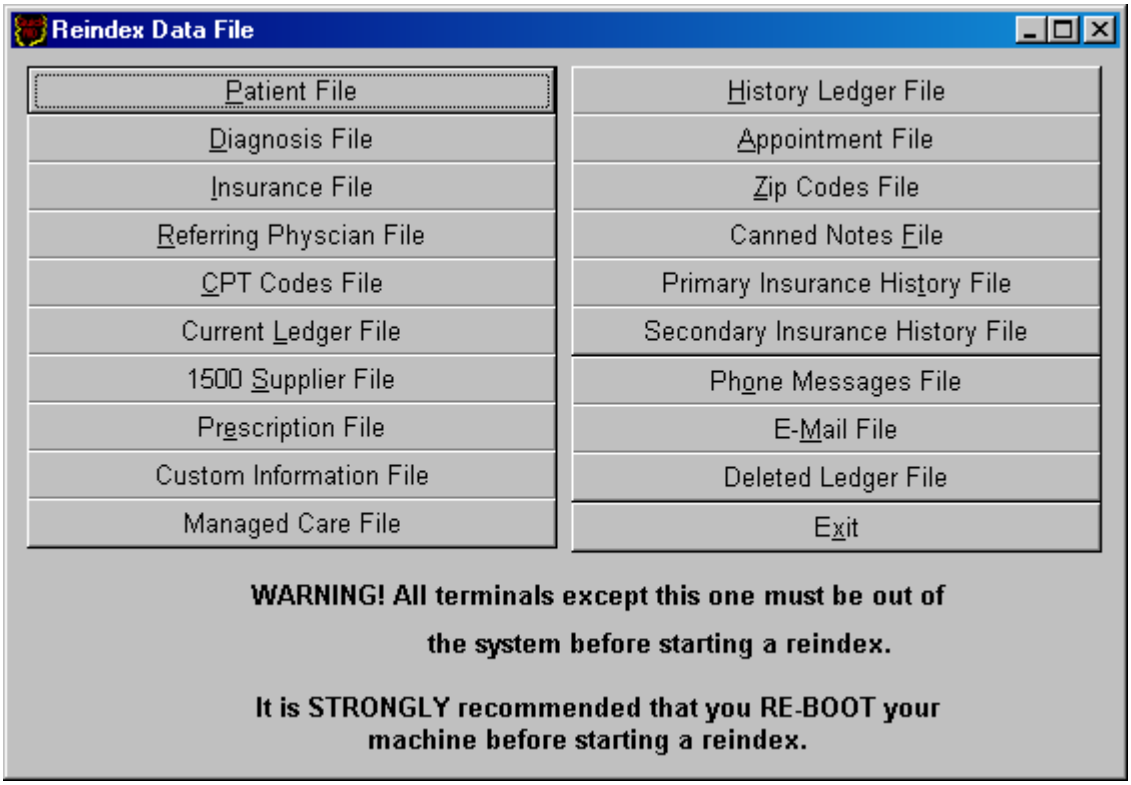

Rebuild Data File
Patient File
Diagnosis File
Insurance File
Referring Physcian File
CPT Codes File
Current Ledger File
Supply File (1500)
Prescriptions File
Custom Information File
Managed Care File
History Ledger File
Appointment File
Zip Codes File
Canned Notes File
Primary Insurance History File
Secondary Insurance History File
Phone Messages File
E-Mail File
Deleted Ledger File
Exit
WARNING! All terminals except this one must be out of the system before starting any rebuild.
You also must have at least the size of the data file being rebuilt free on the drive.
Make SURE you have a good backup before starting.
It is STRONGLY recommended that you RE-BOOT your computer before starting a rebuild.

If a system ISAM error message occurs due to some type of corruption in a file, this feature allows you to rebuild that data file by selecting the file that was made reference to in the error message. Choose the file you wish to rebuild and Quick-MD will ask if you want to rebuild. Choose **<YES>**.

> ***NOTE:*** *Rebuilding a file also re-index's it. Therefore, depending on the size of your database, a rebuild will take much longer to run than a re-index.*

> ***NOTE:*** *The majority of the time an error message comes to the screen it is coming from the Windows operating system itself. You should always make a note of the error message, and then reboot your machine. The majority of the time this will take care of the problem!*

Data Files Re-index



If a system INDEX error message occurs due to a corrupt index, this feature allows you to re-index that data file that was made reference to in the error message by selecting the appropriate file. Choose the file you wish to re-index and Quick-MD will ask if you want to re-index. Choose **<YES>**.

Reset Lock Fields in Appointments

Note: This feature is only used in the standard scheduler!

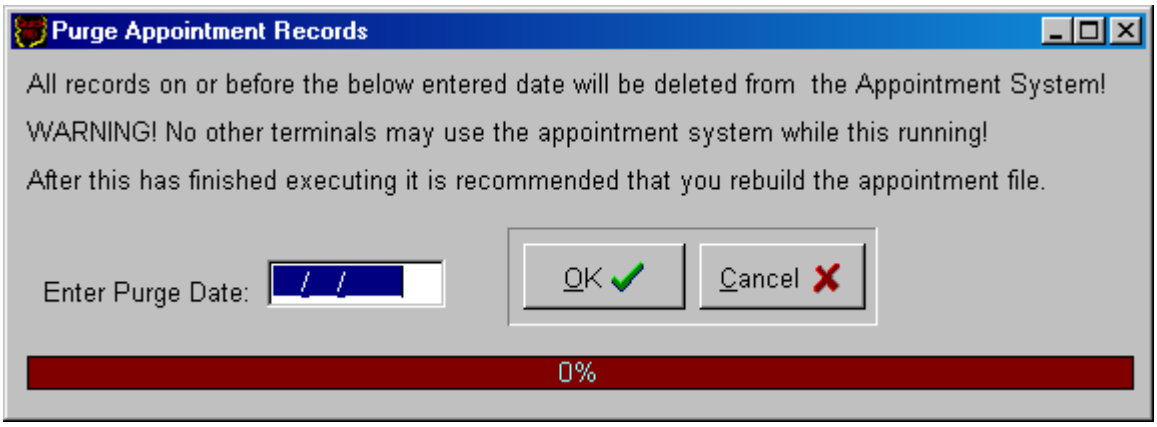


If a system error message occurs in the appointment file this feature allows you to reset lock fields to clear error message and allow the user to continue.

Example: *System error message will display "appointments locked by another terminal"*

Purge Appointment File

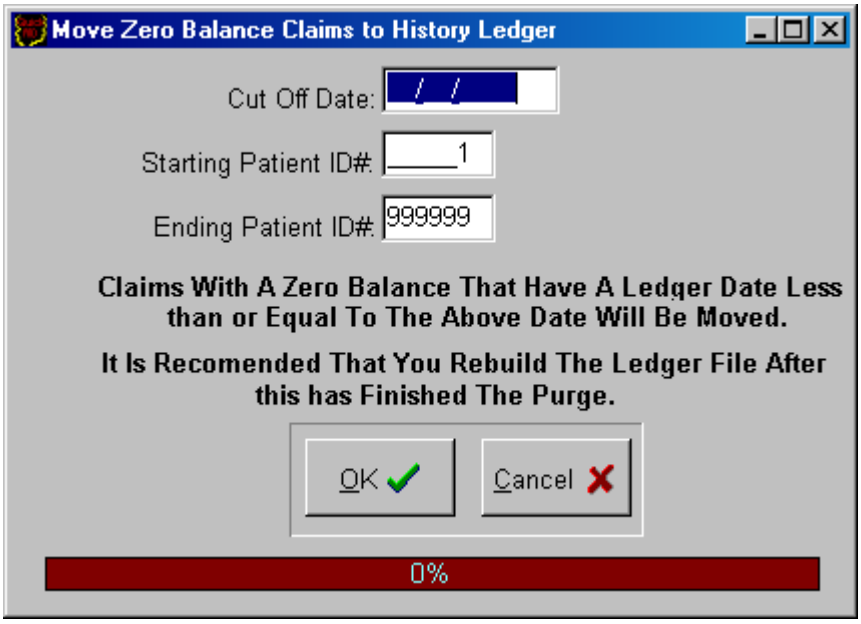
This feature is only used with the standard Scheduler


Purge Appointment Records
All records on or before the below entered date will be deleted from the Appointment System!
WARNING! No other terminals may use the appointment system while this running!
After this has finished executing it is recommended that you rebuild the appointment file.
Enter Purge Date:
/ /
OK
Cancel
0%

This feature allows all records on or before the "entered purge date" to be deleted from the appointment files.

> ***Note:*** *No other terminals can be using the appointment files while purging process is running! After purging process has finished, it is recommended that you rebuild the appointment file.*

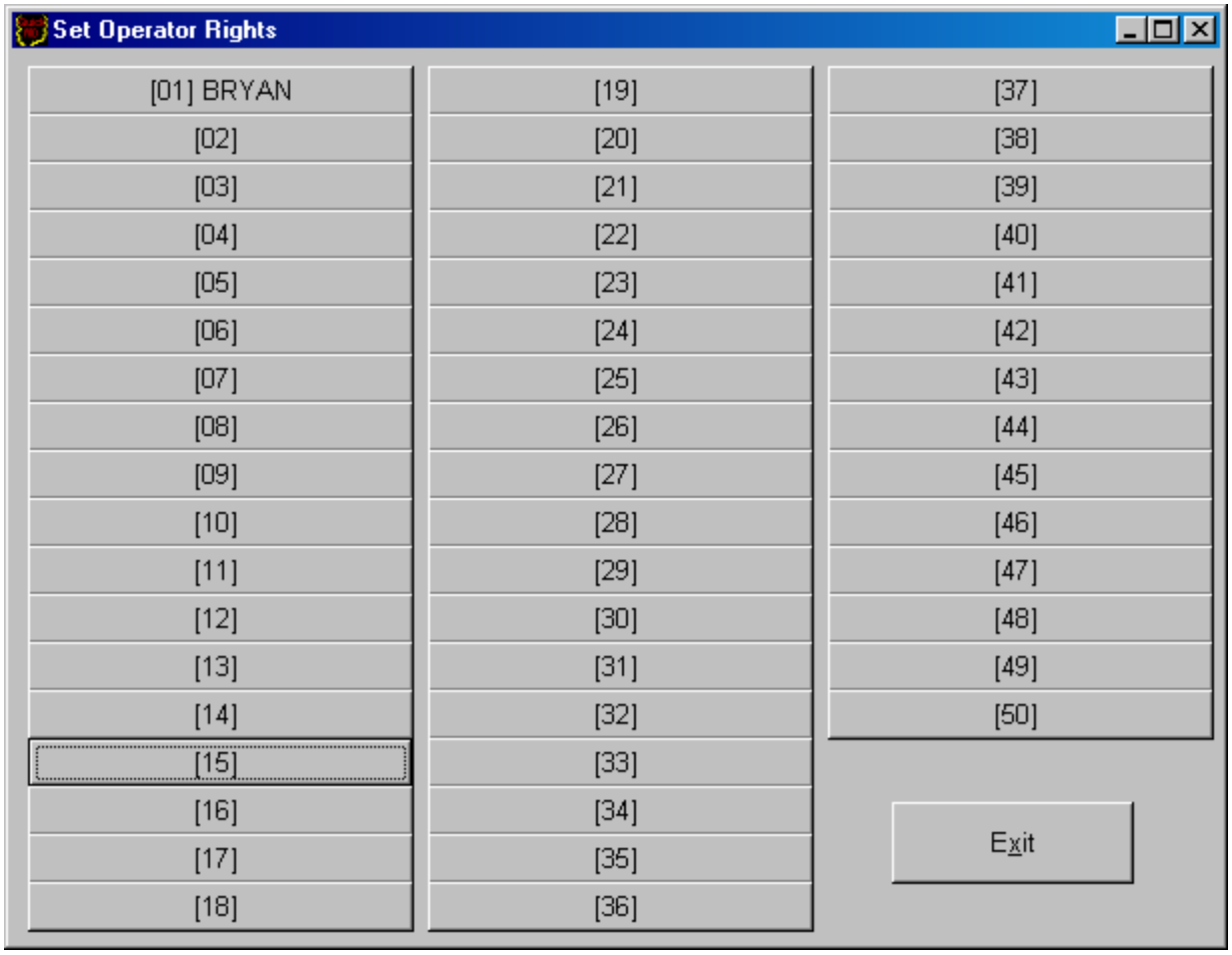
Move Ledgers to History


Move Zero Balance Claims to History Ledger
Cut Off Date:
/ /
Starting Patient ID#:
1
Ending Patient ID#:
999999
Claims With A Zero Balance That Have A Ledger Date Less than or Equal To The Above Date Will Be Moved.
It Is Recomended That You Rebuild The Ledger File After this has Finished The Purge.
OK
Cancel
0%

This feature allows all claims in a Ledger with a zero balance that have a ledger date less than or equal to the selected cut off date to be moved to the patient's History Ledger. After the purging process has finished, it is recommended that you rebuild the Ledger File. Once Patient Ledgers have been moved to History Ledger, no reports can be generated for those claims.

> ***Note:*** *System will only move the Patient accounts you selected.*

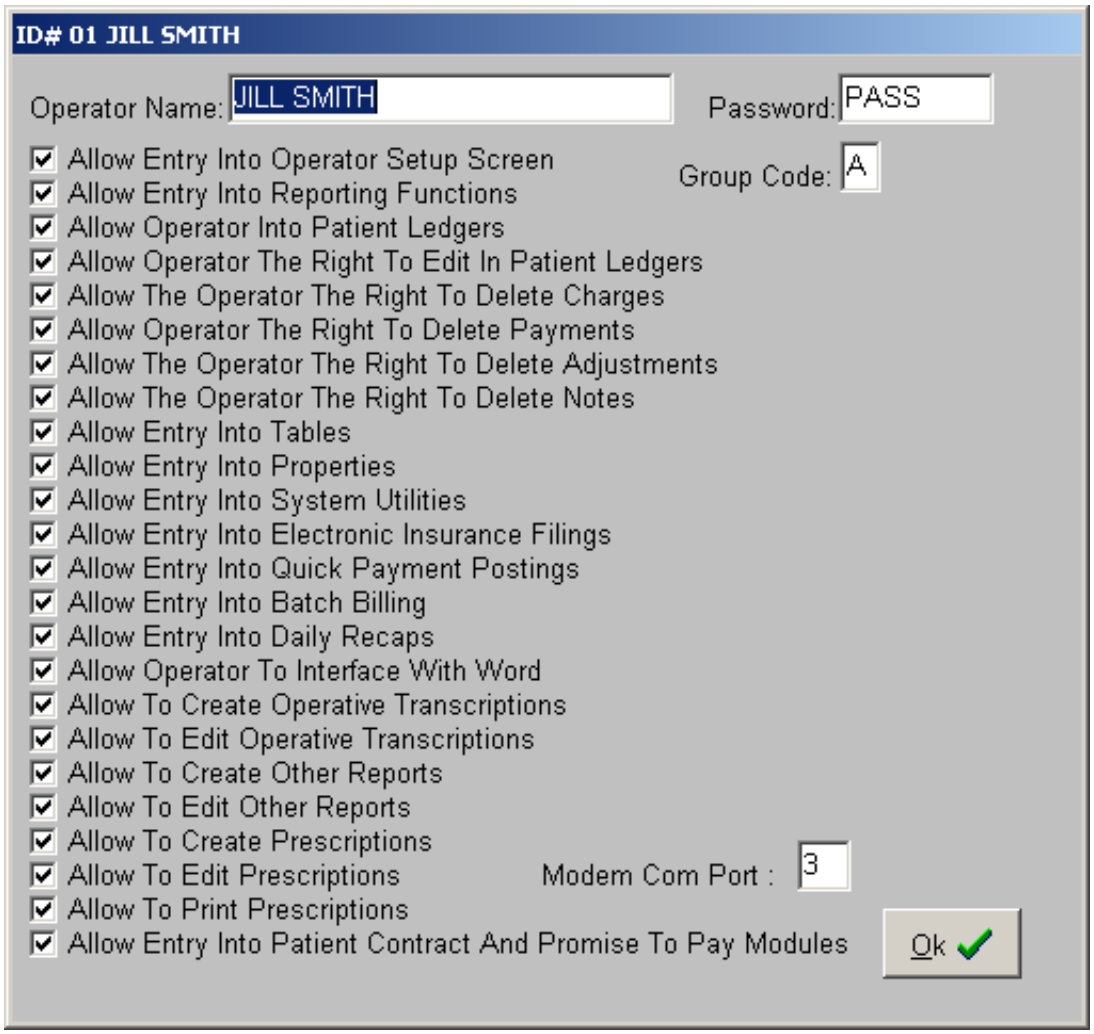
Set Operator Rights



Quick-MD allows for up to fifty users with different ID#'s, passwords and degrees of users rights.

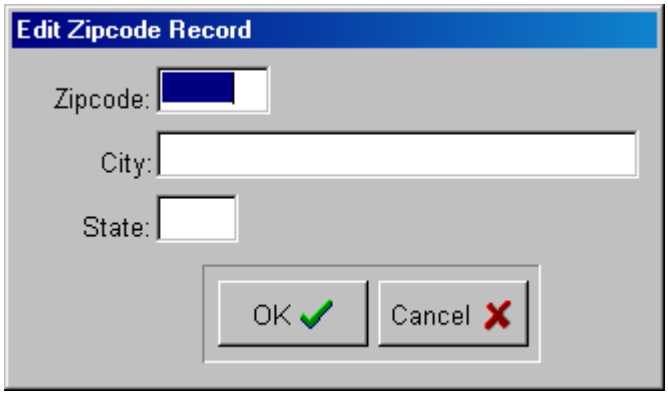
Steps:

1. Select one of the numbered boxes, that number will be this operators (**ID#**) to log on Quick-MD.


ID# 01 JILL SMITH
Operator Name: JILL SMITH
Password: PASS
Group Code: A
Allow Entry Into Operator Setup Screen
Allow Entry Into Reporting Functions
Allow Operator Into Patient Ledgers
Allow Operator The Right To Edit In Patient Ledgers
Allow The Operator The Right To Delete Charges
Allow Operator The Right To Delete Payments
Allow The Operator The Right To Delete Adjustments
Allow The Operator The Right To Delete Notes
Allow Entry Into Tables
Allow Entry Into Properties
Allow Entry Into System Utilities
Allow Entry Into Electronic Insurance Filings
Allow Entry Into Quick Payment Postings
Allow Entry Into Batch Billing
Allow Entry Into Daily Recaps
Allow Operator To Interface With Word
Allow To Create Operative Transcriptions
Allow To Edit Operative Transcriptions
Allow To Create Other Reports
Allow To Edit Other Reports
Allow To Create Prescriptions
Allow To Edit Prescriptions
Modem Com Port : 3
Allow To Print Prescriptions
Allow Entry Into Patient Contract And Promise To Pay Modules
Ok

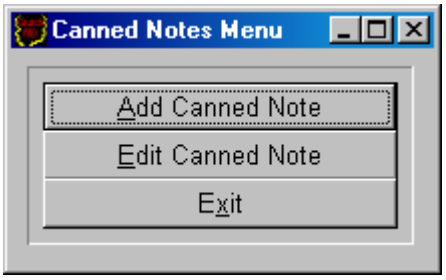
2. Enter **NAME** of the person assigned to ID number
3. Enter **PASSWORD**, this will be their private password to log on Quick Med
4. Click the box to put a check mark by each feature of Quick-MD that this person will be allowed to access.
5. If this user is going to be send claims electronic from within Quick-MD. You will need to set up the com port that windows assigned to the modem on the computer that this user will use to send claims.
6. Set the **Group Code**. The group code allows you to group user together so that you can send email to all of the users that belong to this group at the same time.
7. Select the **<OK>** button to save
8. The user can only access Quick-MD features that have been assigned to them.

Edit Zip Code Record



Use this feature to make changes to existing Zip Code Records. New Zip Code Records can be added from the patient demographics screen from the city field.

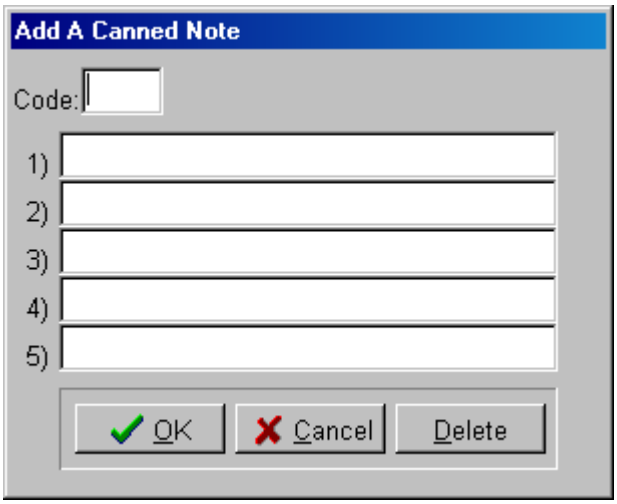
Canned Notes



This feature allows you to add or edit canned notes.

Steps: Part 1. Add Canned Note

To **Add Canned Notes**: Select the button marked **<Add Canned Note>**



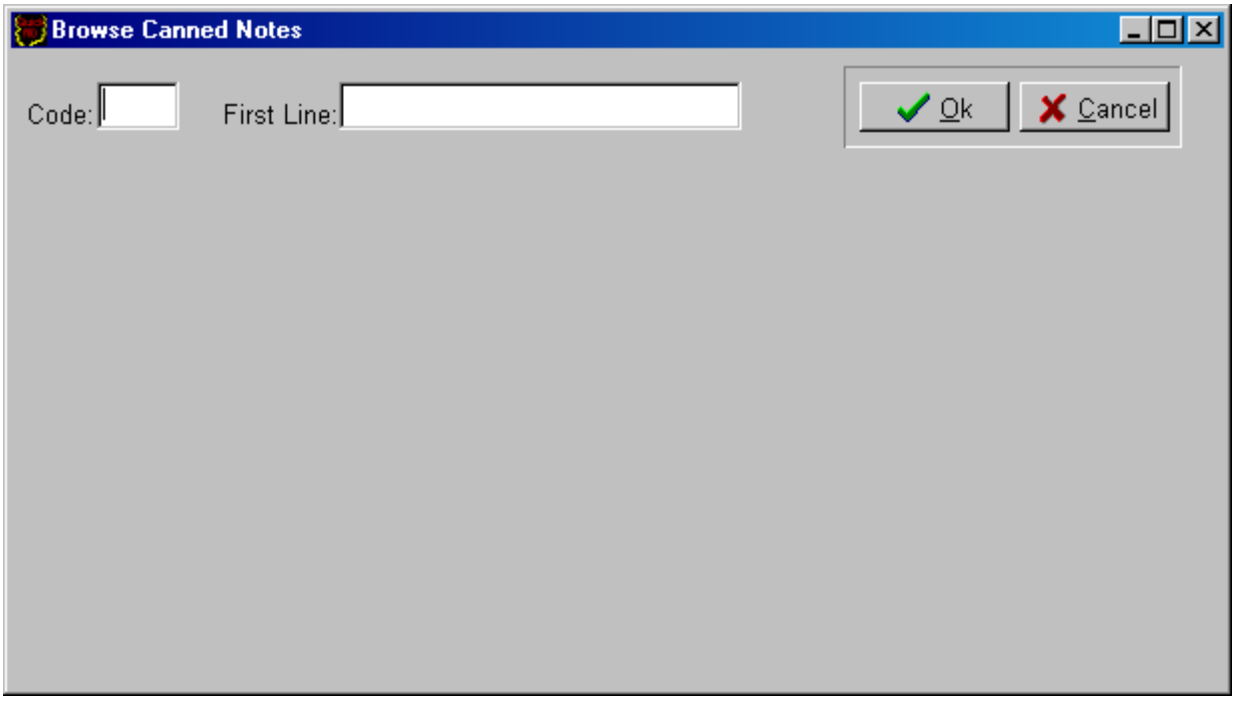
At the box marked “Code:” Enter a three digit alpha, alpha/numeric, or numeric code then hit enter.
In the fields marked 1 through 5, enter up to five lines of notes you wish this code to carry.
Select the **<Ok>** button to save

NOTE: *Canned Notes can be utilized in the Patient Ledger by highlighting the claim you wish the note to be posted to, and hitting F3.*

Part 2.
In "Patient File:" Select the **LEDGER** button
Select the **CURRENT LEDGER**
Highlight the claim to post directly under claim
Select the **<F3>** - Note key
To post a canned note enter the # code then the three digit code (you may type a note in here)
Select the **ENTER** button, then the canned note will appear in "Notation box"
Select the **<OK>** button to post canned note to claim. Canned notes will appear on the Patient's Billing Statement

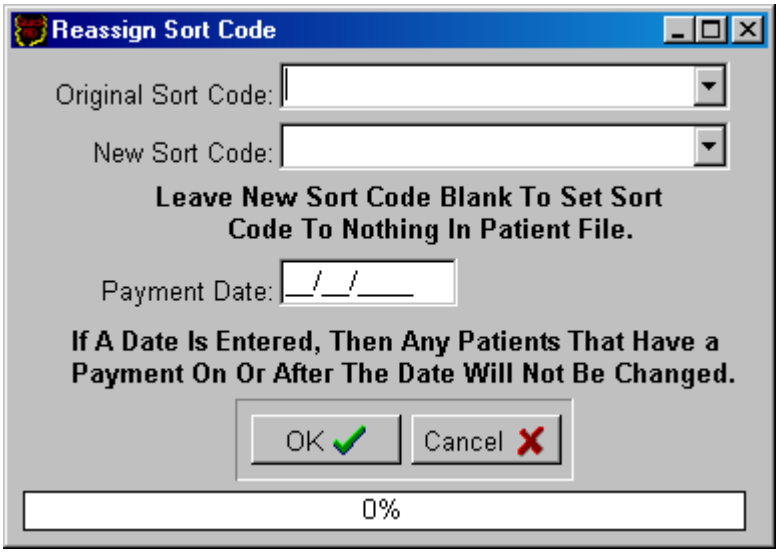
NOTE: *To delete an existing canned note select the* **<DELETE>** *button*

Steps: Part 1. Edit Canned Note
To Edit Canned Notes: Select the button marked "**EDIT CANNED NOTE**"



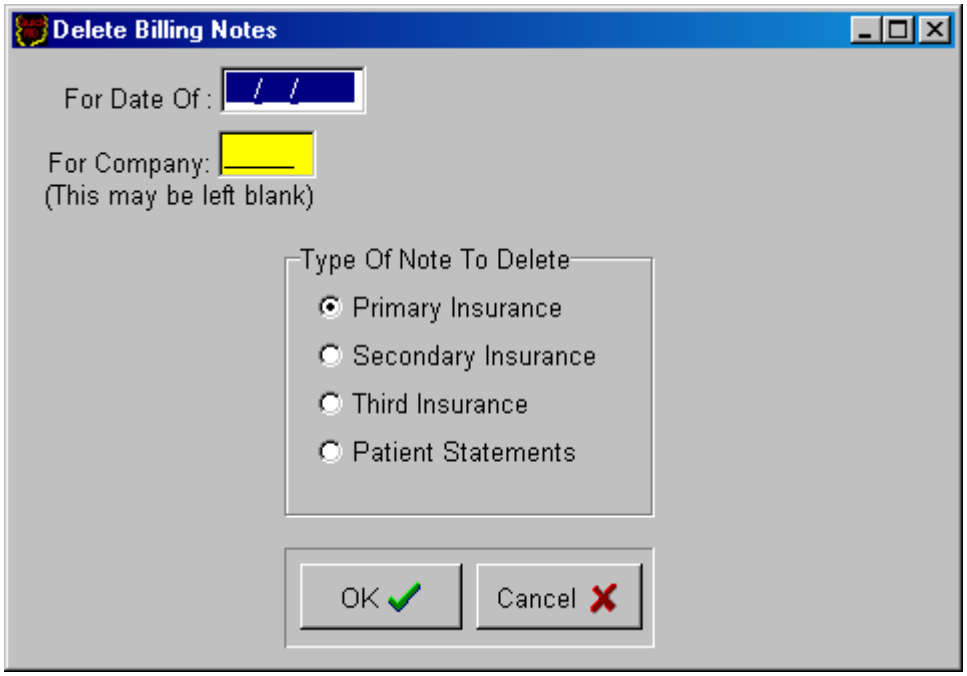
At "Browse Canned Notes: "enter the three digit code
Select the **<OK>** button, then select the **<ENTER>** button to edit a canned note
Select the **<OK>** button to save changes

Reassign Sort Code


Reassign Sort Code
Original Sort Code:
New Sort Code:
Leave New Sort Code Blank To Set Sort Code To Nothing In Patient File.
Payment Date: __/__/____
If A Date Is Entered, Then Any Patients That Have a Payment On Or After The Date Will Not Be Changed.
OK
Cancel
0%

This feature allows you to change existing sort codes in patient files to another predefined sort code. You would normally use this feature to move patients, in the collection letter process, from one collection letter to the next one.

Delete Billing Note



This feature allows you to delete multiple billing notes.

Steps:
For Date Of - enter the billing date you want the billing notes deleted for. Quick-MD will delete all billing notes with the selected responsibility code for that date.

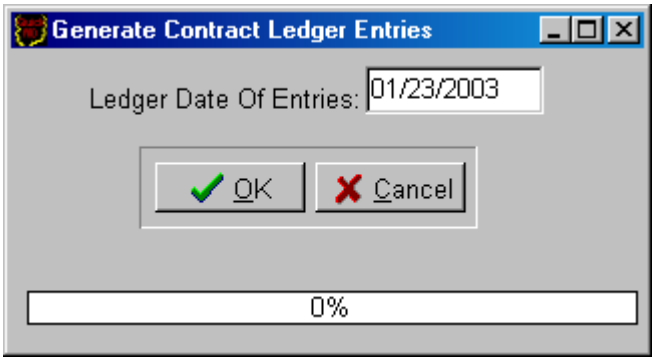
For Company – Can be narrowed down to one company. **<F1>** will allow you to browse the insurance table.

Type of Note To Delete - Click the circle to mark the type of billing notes you want system to delete.

Select the **<OK>** button to process

> ***NOTE:*** *This process will delete ALL billing notes for the date and responsibility selected. . If you leave the ID# field blank it will be ALL billing notes for the date and responsibility selected, both hardcopy and electronically! Be certain that this is the end result you are trying to accomplish!*

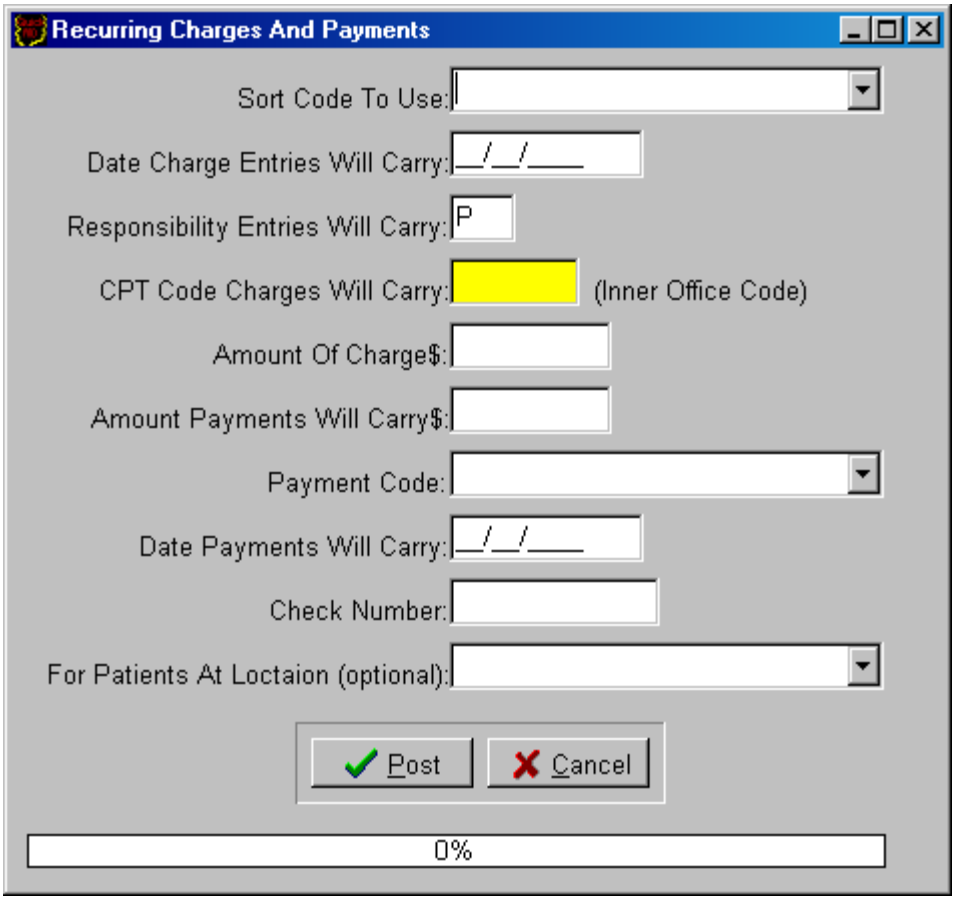
GENERATE CONTRACT LEDGER ENTRIES



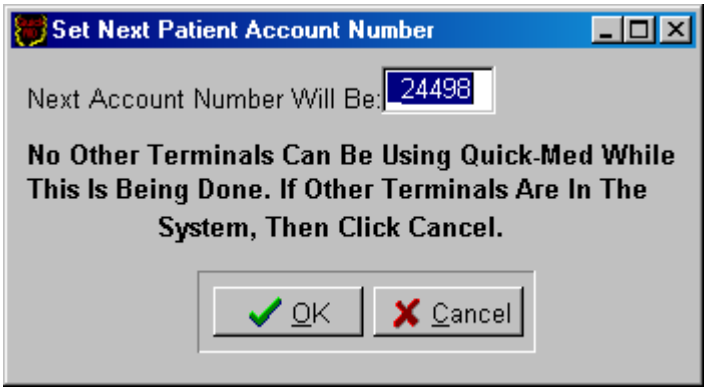
This feature is utilized when patients are set up on a payment plan for a balance owed. First, go to the patient's ledger and write off the amount that you are going to put under contract. It is best to do this with an adjustment code reserved only for this purpose. Using a unique adjustment code will allow you to do reporting based on this code. Next, set up the contract form under patient demographics. The amount you adjusted goes under contract amount and the payment amount that you agree on goes under monthly charge field. When the "generate contract ledger entries" function is run, the agreed upon monthly payment is posted back to the patient's account and a report is generated showing all entries generated on a selected entry date. This process should be run **PRIOR** to generating patient statements so that the monthly amount owed is generated and appear on the patient statement. At the same time, the date and amount of the contract ledger entry will appear in the "Contract" box within the patient file.

POST RE-OCCURING CHARGES AND PAYMENTS

This feature allows Quick-MD to post payments and/or charges to an unlimited number of patients by assigning a sort code to patient on the demographic screen. When this utility is run it will make the ledger entries according to the parameters set below.



Set Next Patient Number

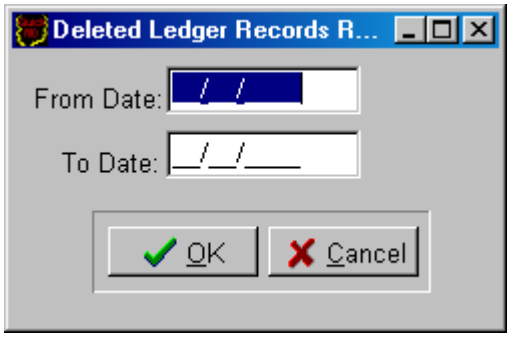

Set Next Patient Account Number
Next Account Number Will Be:24498
No Other Terminals Can Be Using Quick-Med While This Is Being Done. If Other Terminals Are In The System, Then Click Cancel.
OK
Cancel

This feature allows you to select the next Patient ID number. System automatically assigns each new Patient an ID number in numeric order. When utilizing this feature, Quick-MD will assign the next new Patient the ID number you selected.

> ***Warning:*** *No other terminals can be using Quick-MD while this feature is being utilized.*

Run Deleted Records Ledger Report

Use this feature to run a report of all Ledger Entries that have been deleted from the system and which operators deleted them. The report generated contains the following fields: **Date Deleted**, **Operator**, **Patient Id#**, **Name**, **Type**, **Ledger Date**, **Service Date**, **Description of Entry**, **Amount**, **Claim#**, **Invoice#** and **Provider**.



FROM DATE - Select a starting date range

TO DATE – Select an ending date range

Select **<OK>** to run the report.

CHECK FOR ORPHANED LEDGERS
Use this feature to run a report on ledgers that do not have a patient file attached to them. If an orphaned ledger is found, then create a patient file with the ID# listed in the report. After the patient file is added the ledger will be attached to it.

INTRA-OFFICE EMAIL

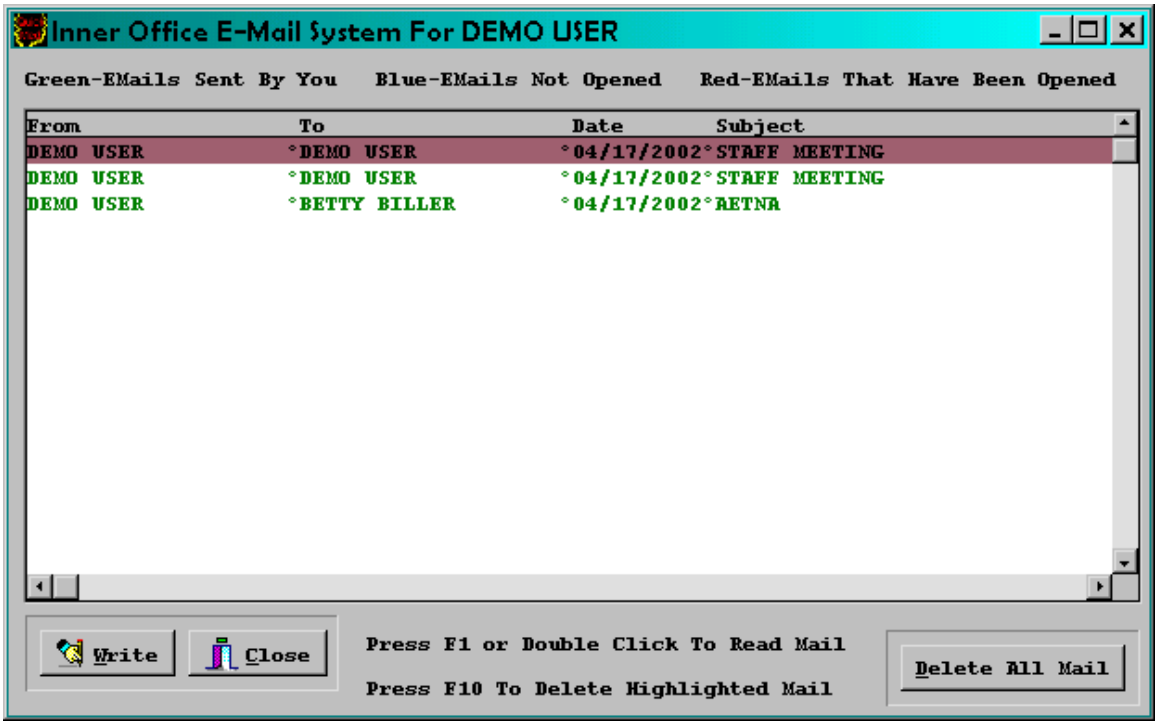
Intra Office Email is available to all users of Quick-MD if they are logged into Quick-MD with their own ID number and password. Quick-MD will automatically notify the operator of an incoming email as they move around in the system, if this feature is turned on in **Properties/Miscellaneous Defaults/Auto Check Email.**

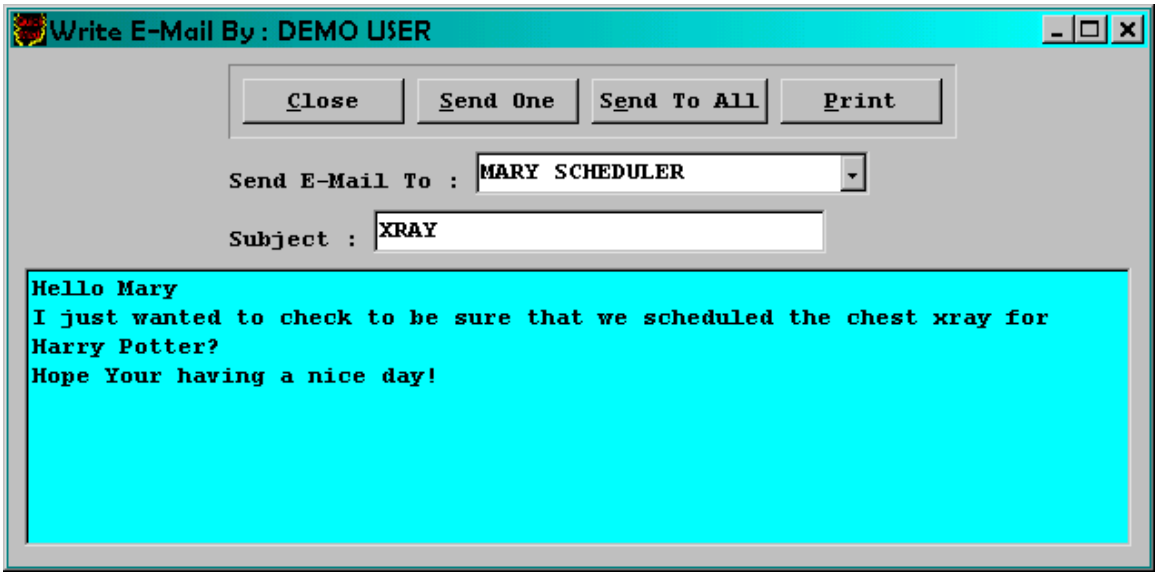
The email button is available to send new emails from the front screen of **Quick-MD**, the front screen of the **Scheduler**, and from the **Electronic Medical Records/Phone Messages/New Message screen.**


Version 4.3 (C)Copyright Michel & Pratt Consulting, Inc. 1998-2002
File Billing Recaps Tables Payments Reports Properties E-Bill (NSF) E-Bill (ANSI) System Utilities
Operator : BRYAN
Quick-MD®
"A Professional Physician's Practice Management System"
Confirm
You have mail. Open E-Mail system?
Yes
No

SENDING AN EMAIL

To send an email, click the **Email Icon or Button**, depending on the location you are at (Front Screen, Scheduler, or Phone Messages in EMR) then press the **WRITE** button at the bottom left hand corner of the window.





The operator will have the option of sending to one operator or all users of Quick-MD at once. Quick-MD tracks the email sent and received by you and which ones that have and have not been read. All commands are across the top and bottom of the opening window.

WAITING ROOM WIZARD

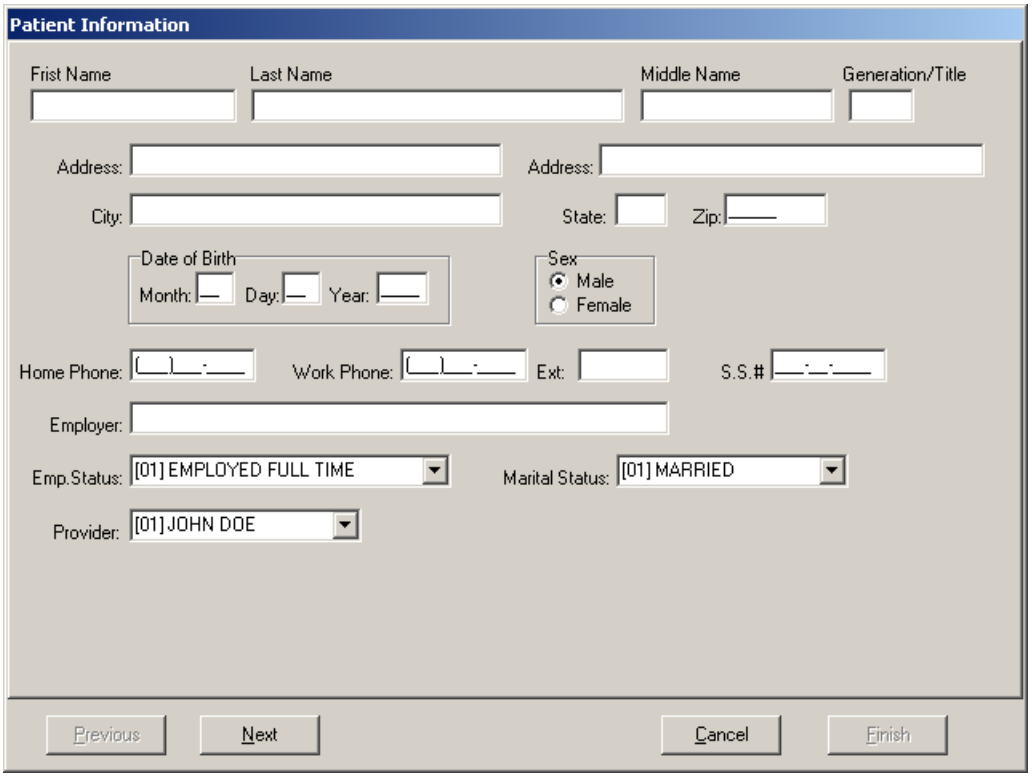
Quick-MD comes with a wizard that allows patients to enter their demographics electronically.

STARTING THE WIZARD

The waiting room wizard will excepts a few command line parameters. You can enter these parameters behind the executable to control certain aspects of the program.

-w Keeps the wizard from running full screen.
-d <milliseconds> This option controls how long the thank you screen will be displayed.

PATIENT INFORMATION

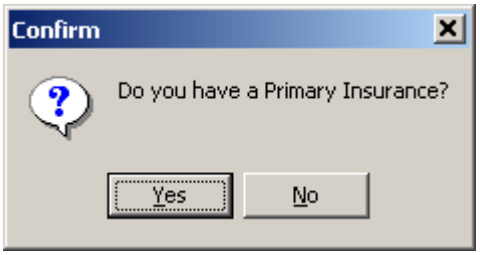


From this screen the patient can enter the following information:

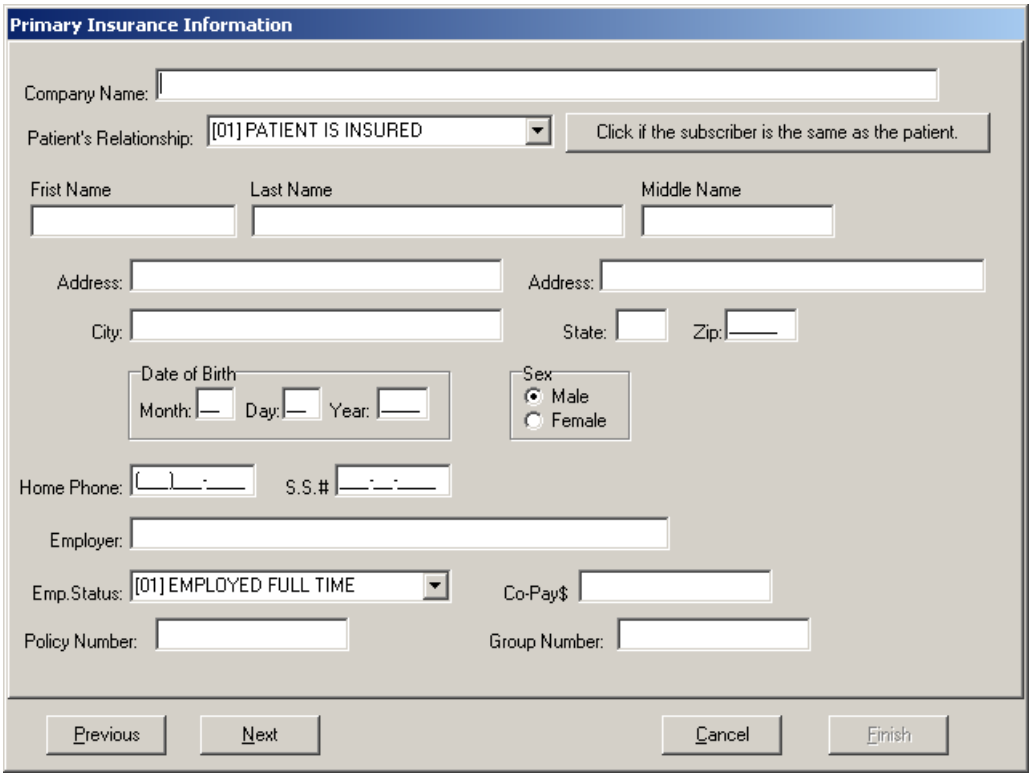
- Patient Name
- First and Second Address, City, State and Zip
- Date of Birth
- Sex
- Home phone number
- Work phone number and extension
- Social Security
- Employer
- Employee Status
- Marital Status
- Provider

Primary Insurance Information

When the patient has finished entering the main information, the wizard will ask if they have a primary insurance.

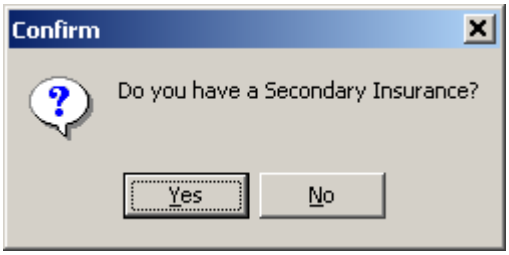


If the patient answers yes the **Primary Insurance Information** screen will be displayed.



If the patient is the insured, the patient can click on the button labeled as **"Click if the subscriber is the same as the patient"** and the wizard will bring over the information from the **Patient Information** screen. If the patient is not the insured then they will need to fill out the information.

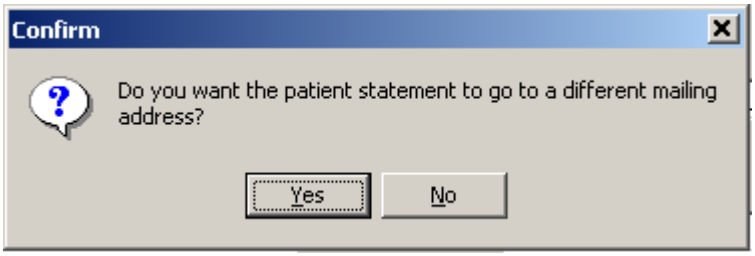
After the **Primary Insurance Information** is entered the wizard will ask the user if they have a secondary insurance company.



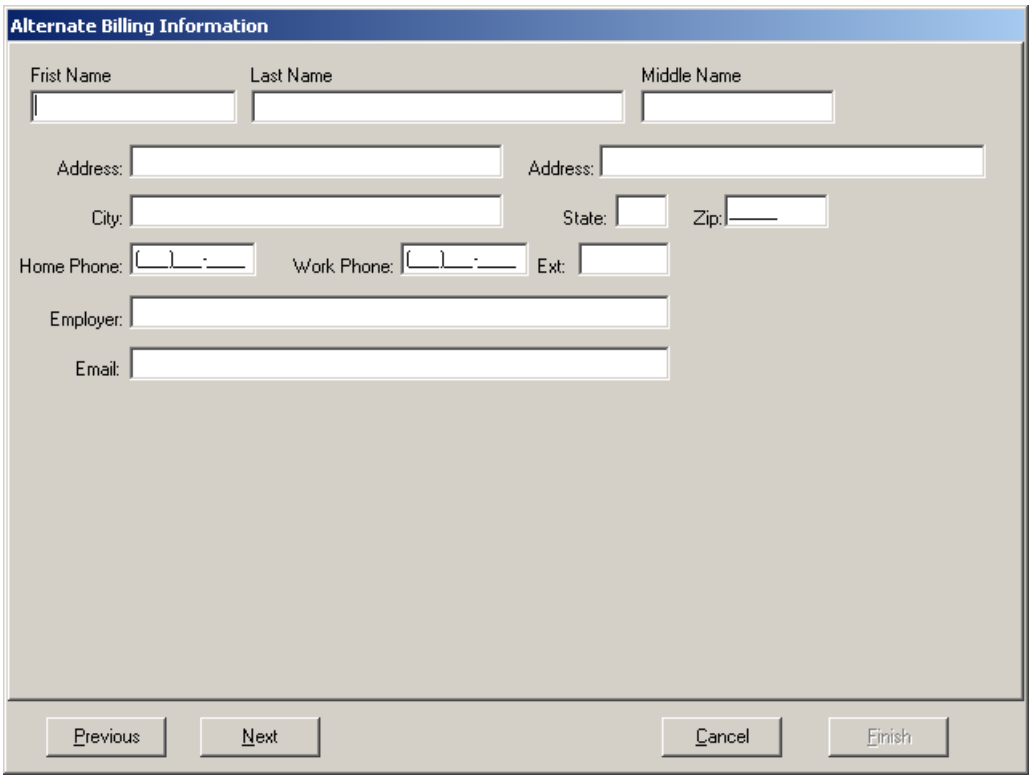
If the patient answers yes, the wizard will display a screen identical to the **Primary Insurance Information** screen. On the **Secondary Insurance Information** screen the patient can enter their secondary information.

Alternate Billing Information

After the patient has finished with their insurance information, the system will ask them if they want the patient statement to go to a different address.

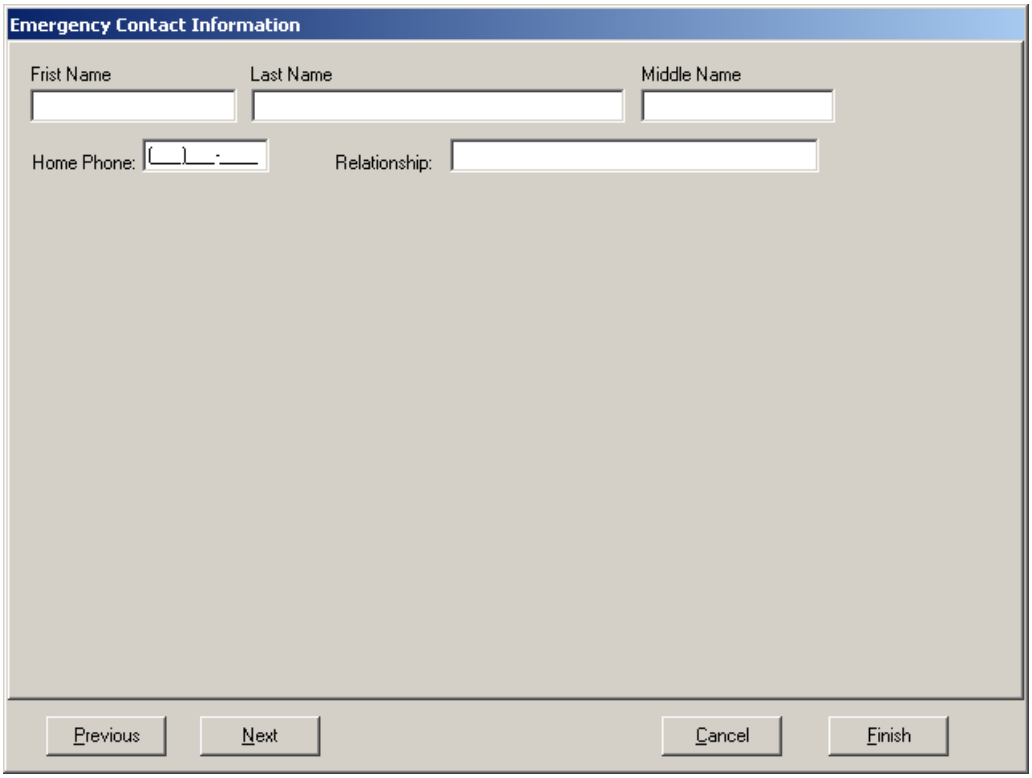


If the patient answers yes the **Alternate Billing Information** screen will be displayed. From here the patient can enter the name and address information that will appear on the patient's statement.

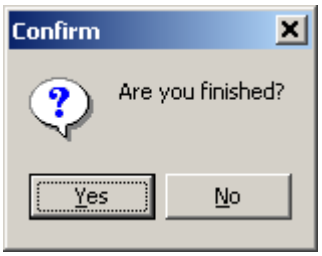


Emergency Contact Information

The **Emergency Contact Information** screen contains the person that needs to be contacted in case of an emergency.



At this point the **Next** or the **Finish** button will cause the wizard to ask the patient if they are finished entering their information.



If the patient answers yes a thank you message will be displayed for a few seconds, then the wizard will return to the **Patient Information** screen.

To exit the waiting room wizard press **<F1>** and type down in the password field.

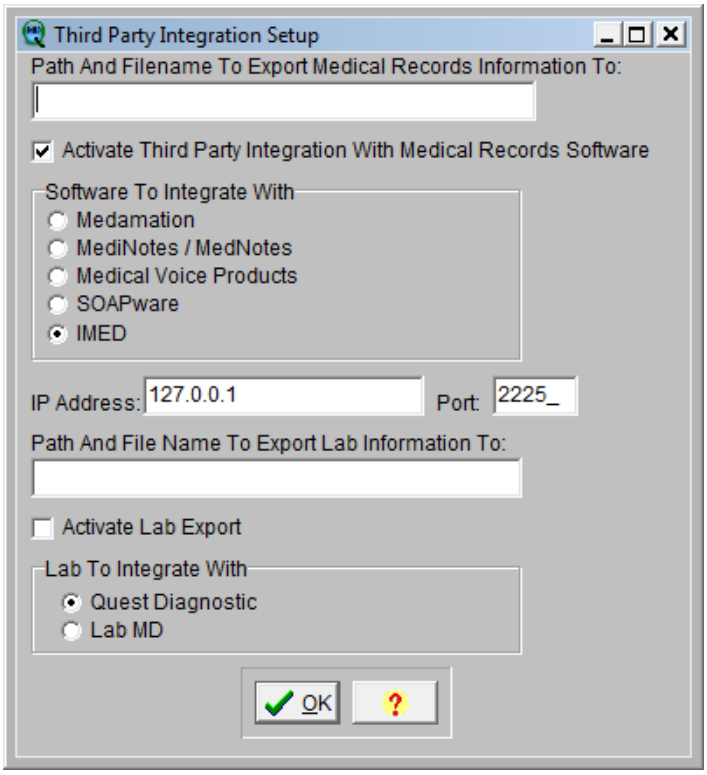
Accessing The Waiting Room Information

From Quick-MD the waiting room table can be accessed easily from the patient demographics screen *(for more information see page 147)*

SETTING UP AND USING THE HL7 INTERFACE

Quick-MD can send patients and appointments to EMR systems that except HL7 messages. It can also read electronic super bill from a select number of EMR packages.

SETTING UP THE HL7 INTERFACE TO SEND MESSAGE



1. Go to properties, Miscellaneous Defaults, and third party integration.
2. Check the box labeled Activate Third Party Integration with Medical Records Software
3. Select IMED under Software to Integrate with.
4. Get the IP address and port number from the EMR vendor. If the EMR's HL7 server is running on the same machine as imedscan.exe you can use the loop back address 127.0.0.1. The port number is always going to be dependent on the EMR company.
5. Place imedscan.exe in the startup directory of windows. You only want imedscan.exe to run on the server. It should not be running on any client machines. If you want to run imedscan.exe as a service see the instructions below.

The program imedscan.exe must be running on the server.

RUNNING IMED SCAN AS A SERVICE

If no one logs into your server when it boots you may want to setup imedscan as a service. This will allow imed scan to start at startup without a user having to login.

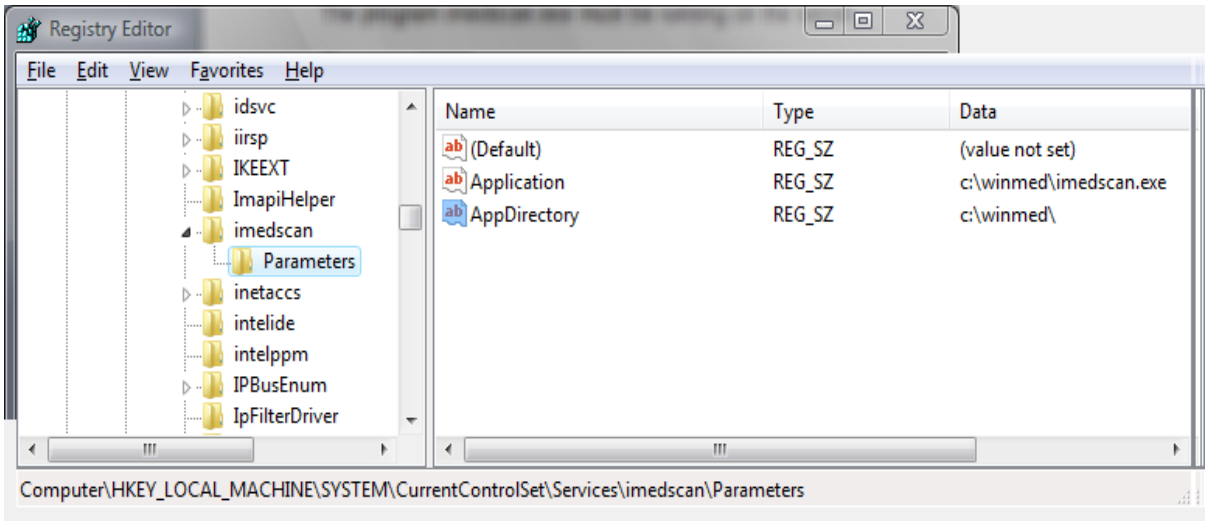
WARNING: *Editing the registry in windows can be dangerous. If you don't feel comfortable editing the registry or working with regedit then do not try to setup imed scan as a service. It is always a good idea to backup the registry before making any changes.*

We will be using the programs INSTSRV.EXE and SRVANY.EXE that come with windows. If you do not have these programs then you will need to download the Resource Kit from Microsoft. These programs only needed to be run from the command line once. They allow you to run any program as a service.

1. Run the program to install the service

C:\>"C:\Program Files\Windows Resource Kits\Tools\instsrv.exe" imedscan "c:\Program Files\Windows Resource Kits\Tools\srvany.exe"

2. Start the program regedit
3. Go to key **HKEY_LOCAL_MACHINE\SYSTEM\CurrentControlSet\Services\imedscan**
4. Go to the **Edit** menu and click on Add. This will create a new key name the key **Parameters**.
5. Double click on the new Parameters key.
6. Go to the **Edit** menu and click **New String Value**
7. Set the values name to **Application** set the values data to the path of imed scan (c:\qmed\imedscan.exe).
8. Add Another **New String Value** call this one **AppDirectory** set this values data to imed scans working directory (c:\qmed\)
9. Close regedit



To start or restart the service you will go to the Control Panel, Administrative Tools and Double Click on Services. At this point you should see an entry for imedscan. Highlight that entry and choose the action that you want to perform (Start, Restart or Pause)

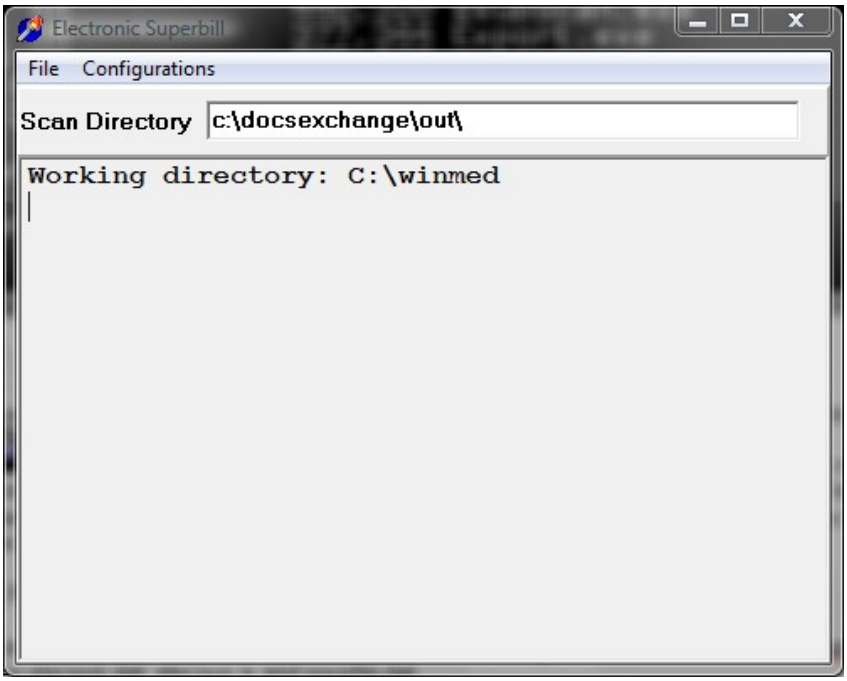
Note: *All path setup in the register and used by the HL7 programs should point to a local directory when used as a service. The service runs as a different user and may not have these directories mapped the same way.*

IMED SCAN

When imedscan.exe is started it will immediately minimize to the task bar. You can get to the menu by right clicking on the  icon in the task bar. If you need change the amount of time that imed scan waits between scans then click on “Set Scan Time” from the imed scan menu. The scan time is in milliseconds and is set to 5000 (5 seconds) by default. The main form option of the menu will bring up a screen that will let you manually run a scan. If you need to close imed scan then choose exit from the menu.

Logging is always on for imedscan. The log file is stored in the Quick-MD data directory as imedque.log. If this file is not found you may need to update the imedscan executable.

Setting up the HL7 interface to read electronic super bills



To install the electronic superbill reader you will need to install the program esupScan.exe into the qmed directory along with the files elecsup.dat, elecsup.ix and esupfig.dat.

Like imedscan.exe esupscan.exe will need to be running at all times on your server.

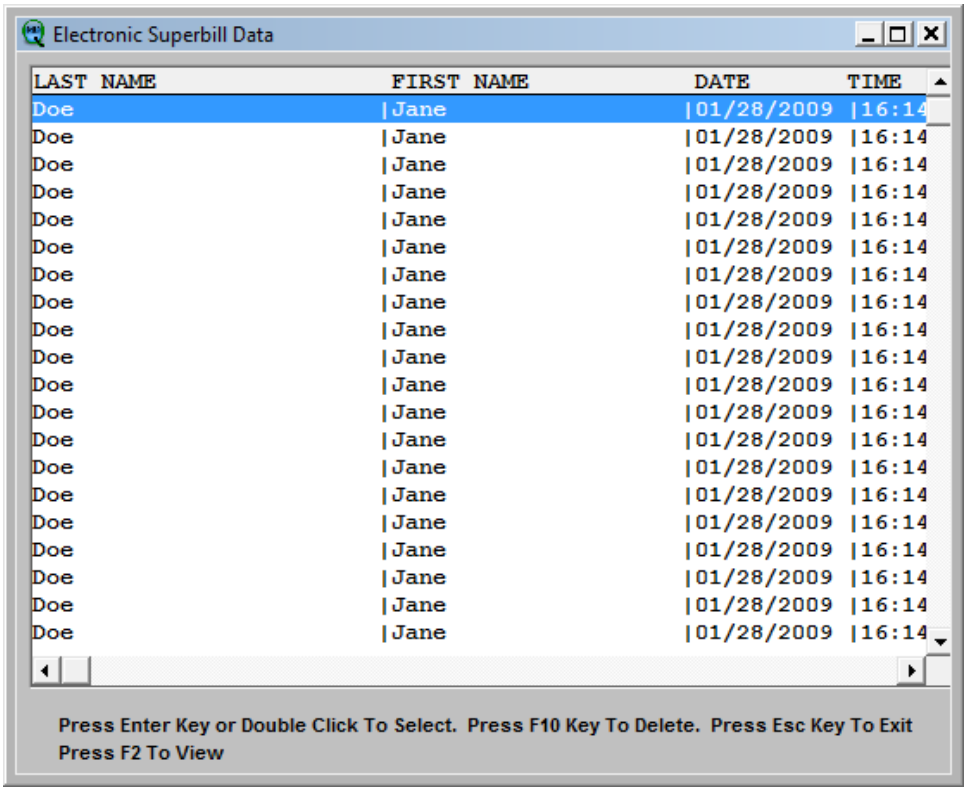
You will need to find out what directory the EMR program is writing the electronic superbill files to. You will put this directory in the Scan Directory field. After you type in the scan directory press enter for the new scan directory to be saved.

Under the Configurations Menu you can Turn Logging on or off by clicking on the log button. If logging is on, all message information will be saved to a log file name esup.log in the working directory. The Scan Time option will let you change the scan time by milliseconds. Set Import System will let you choose which EMR you are expecting electronic superbill messages from.

You can configure this program to write a log file to the Quick-MD data directory by clicking on the log item under configurations. This will put a check next to the item. If the check is already there then the logging feature is on. You can check the log by opening the file esup.log.

Loading electronic superbills

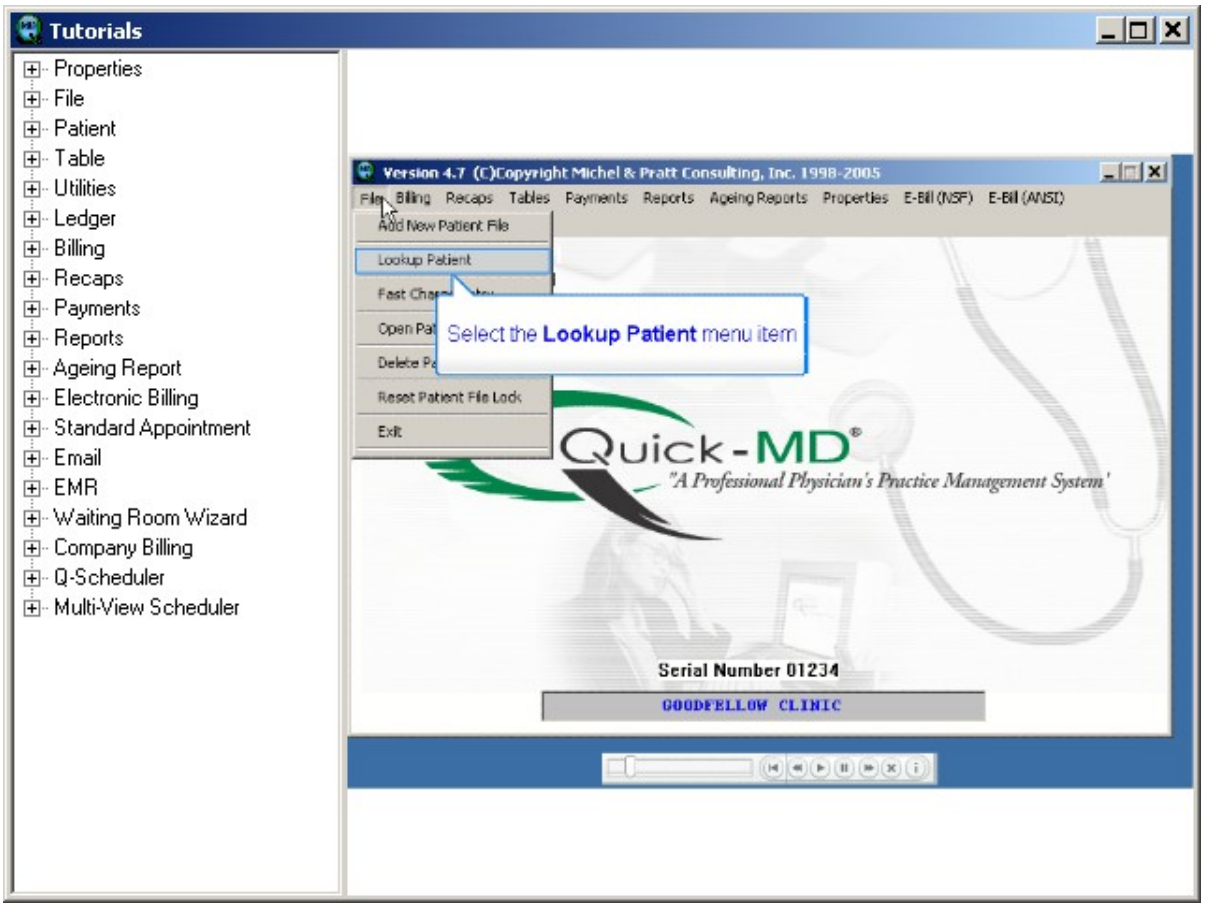
From Quick-MD go to System Utilities and then Electronic Super Bills.


Electronic Superbill Data
LAST NAME | FIRST NAME | DATE | TIME
Doe | Jane | 01/28/2009 | 16:14
Press Enter Key or Double Click To Select. Press F10 Key To Delete. Press Esc Key To Exit
Press F2 To View

This will bring up the electronic superbill browser. From this screen **F2** will generate a report telling you what information the EMR passed to Quick-MD in the electronic superbill. **F10** will delete an item that you do not want. You can load the electronic superbill into the charge entry screen by Double Clicking on the item that you want or by highlighting the item and pressing enter. If Quick-MD encounters errors while trying to load a electronic superbill it will generate an error report. If no errors are encountered Quick-MD will go directly to the charge entry screen and allow you to complete the charges.

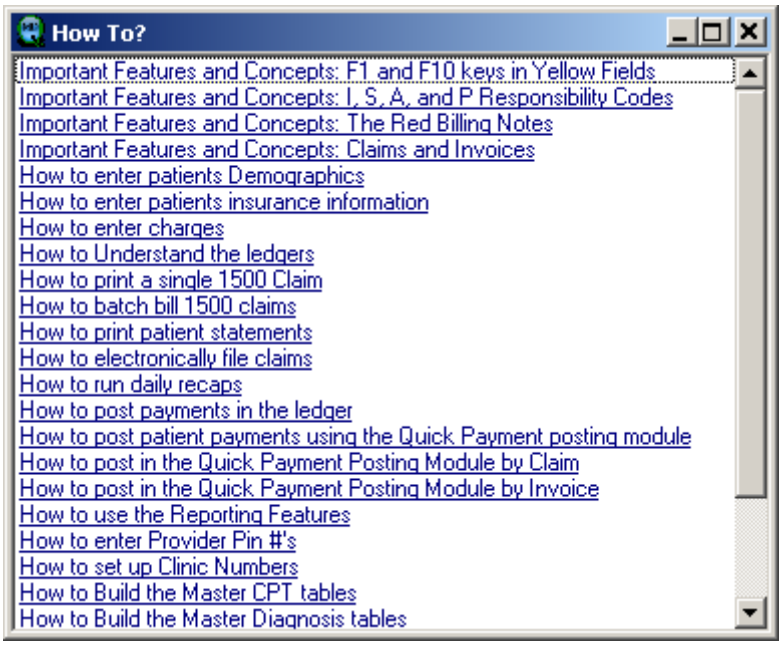
ONLINE TUTORIALS

Quick-MD comes with a collection of tutorials that explain every screen of the system. Tutorials can be accessed by clicking a help button  , or by picking the tutorial from the list on left-hand side of the tutorial player. The tutorials on the left-hand side of the form are grouped in logical sections that match the main menu of Quick-MD. Clicking on the plus sign next to the section heading will expand the list and let you pick a certain tutorial.


Tutorials
Properties
File
Patient
Table
Utilities
Ledger
Billing
Recaps
Payments
Reports
Ageing Report
Electronic Billing
Standard Appointment
Email
EMR
Waiting Room Wizard
Company Billing
Q-Scheduler
Multi-View Scheduler
Version 4.7 (C)Copyright Michel & Pratt Consulting, Inc. 1998-2005
File Billing Recaps Tables Payments Reports Ageing Reports Properties E-Bill (NSF) E-Bill (ANSI)
Add New Patient File
Lookup Patient
Reset Patient File Lock
Exit
Select the Lookup Patient menu item
Quick-MD®
"A Professional Physician's Practice Management System"
Serial Number 01234
GOODFELLOW CLINIC

HOW TO

Quick-MD has easy to access tutorials that explain how to perform common operations in the system. You can access this list from the “How To” item on the main menu. Clicking on the “How To” item will bring up a list of common questions. To view a tutorial, double click on the line that you are interested in.


How To?
Important Features and Concepts: F1 and F10 keys in Yellow Fields
Important Features and Concepts: I, S, A, and P Responsibility Codes
Important Features and Concepts: The Red Billing Notes
Important Features and Concepts: Claims and Invoices
How to enter patients Demographics
How to enter patients insurance information
How to enter charges
How to Understand the ledgers
How to print a single 1500 Claim
How to batch bill 1500 claims
How to print patient statements
How to electronically file claims
How to run daily recaps
How to post payments in the ledger
How to post patient payments using the Quick Payment posting module
How to post in the Quick Payment Posting Module by Claim
How to post in the Quick Payment Posting Module by Invoice
How to use the Reporting Features
How to enter Provider Pin #'s
How to set up Clinic Numbers
How to Build the Master CPT tables
How to Build the Master Diagnosis tables

FREQUENTLY ASKED QUESTIONS

What does a claim consist of?

A claim in this system is a single charge or group of charges along with the charge(s) associated payments, adjustments, and notations. Quick-MD will assign a claim number when a new claim is created. Within each claim, each individual charge will be given distinct invoice numbers. When you are posting payments, adjustments, and notations to the ledger, you will be posting them to a claim and invoice number.

A claim will also contain billing notations put in by Quick-MD. Whenever an insurance company or the guarantor is billed, Quick-MD will place a notation entry in the patient’s ledger saying who was billed, when they were billed, and the amount of the bill. These billing notations also have their own invoice numbers. A primary insurance billing notation will have an invoice number of 1000, a secondary insurance billing notation will have an invoice number of 1001, a third insurance billing notation will have an invoice number of 1002, and a patient billing notation will have an invoice number of 1003. Do not delete these invoices. Quick-MD uses them to determine if the responsible parties listed on the claim have been billed.

Quick-MD will consider the claim paid when there is a zero balance on the claim. All claims must reach a zero balance at some time, whether by payment or write off, so post all payments and adjustments to the claim they are intended to pay or adjust.

What are Responsibilities Codes?

Quick-MD uses four responsibility codes in determining who is responsible for the claim. (I = Primary Insurance, S=Secondary insurance, A = Third Insurance, P = Patient) All ledger entries will contain one or more of these responsibility codes. For example, if we enter a claim where only the patient will be responsible for the bill, only the "P" responsibility will be placed on the ledger entries for the claim. If we enter a claim that the primary insurance company will pay and the balance will be written off, we would enter the "I" responsibility on the ledger entries for the claim. In short, when one of the responsibility codes is placed on a ledger entry, then Quick-MD considers that party responsible for the balance of the claim.

What types of Billing Methods does Quick-MD have?

This system supports three types of billing methods. You may use any of the three methods at any time. In other words, you may have a patient that you will use one method on and another patient that you will use another method on. You can even mix methods within one patient's ledger.

1. **Reassignment Method** - This method adds or changes the responsibility codes during the process of collecting payment on a claim. For example, we have entered a claim for a patient that has primary and secondary insurance, and he will be responsible for what is not paid by the insurance companies. When we first enter his claim we place only the "I" (primary) responsibilities on the charges. The primary insurance is then billed. When the payment from the primary is posted we then add the "S" (secondary) responsibility to the charges on this claim. The secondary insurance company will now be billed. When the payment for the secondary insurance is posted, we then add the "P" (patient) responsibility to the charges and the patient will now be billed for the balance on the claim. By using the reassignment method of billing, responsible parties with the lower precedence do not receive bills until the responsible parties with the higher precedence have paid.

2. **% Method** - By using this method you will add all responsible parties responsibility code to the charges when you first enter the charges. Quick-MD will now bill all the responsible parties for the entire bill.

3. **Co-percent method** -This feature of the medical system allows you to bill the patient at the same time as the insurance company for the percentage of the bill that the insurance company is not going to pay. Using this feature will decrease the practice's receivables. Steps for implementing This feature are listed below:

   a. Set the patients co-percent amount in the patient's financial information record. For example, if the patient's co-percent amount is 20 %, then enter the number 20 in this data field. This MUST be done first.

   b. When entering a insurance claim that you wish to bill the patient for the co-percent, place the “I” and “P” responsibilities on all of the charges for the claim.

   c. Post a co-percentage billing note to the claim. This is done the same way as posting a regular note, but this note's description must start with a percent sign. You may enter anything you wish after the percent sign. The location of the note within the claim does not matter.

      EXAMPLE - % CO-PERCENTAGE BILLING

      As long as this note is attached to the claim the patient will be billed for his set co-percent of this claim until that balance is paid. If after you have received payment from the insurance company and it turns out that the patient is going to be responsible for more than the set co-percent amount the steps to take are:
      (1) Post the insurance payment to the claim.
      (2) Delete the co-percent note.
      Quick-MD will now ignore the co-percent and bill the patient for the entire balance of the claim.

What date is used to determine what information is on the daily recap?

Quick-MD uses the ledger date for all reports and NOT the dates of service. The dates of service are used for reference and on the 1500 form.

How do I perform recaps for only the work I did?

Quick-MD allows users to perform summary or detailed recaps by operator. For this concept to work properly, it is crucial that each operator has their own login into Quick-MD. It is also important that each user verify the “Operator” name on the main screen. This insures that they are working at a terminal that logged in using their ID number.

Can I Change the Font Size on my Reports?

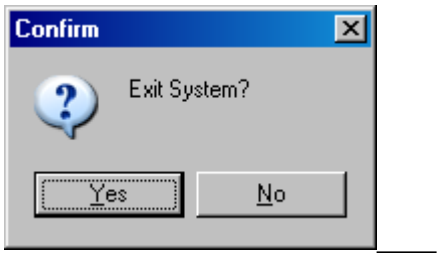
Yes, font size changes are performed via the Printer Settings Menu located under the Properties Menu. *(for more information see page 85)*

Why do my HCFA forms, Patient Statements or SuperBills not line up from top to bottom?
If your HCFA forms, Patient Statements or SuperBills are not lining up from top to bottom, or certain fields are appearing to high or too low, you can fix this by adjusting the dithers found under Printer Settings located in the Properties menu. *(for more information see page 85)*

How do I clear a file lock?
If you get a locking error, for a certain patient, then go to the file menu, then reset patient file lock. On the reset patient file lock form enter the ID of the patient that is locked then click O.K.. If you are getting locking errors in the appointment system then go to the properties or settings section of the appointment system and click on the button labeled “Reset lock fields”.

EXITING QUICK-MD

1. At “Quick-MD’s Main Menu:” Select the File button
2. At “drop down menu:” Select Exit



3. At “Confirm:” Select the <YES> button to confirm the Exit of Quick -MD